DEFENSE CENTERS OF EXCELLENCE
For Psychological Health & Traumatic Brain Injury

VA/DoD Clinical Practice Guideline for Management of Major Depressive Disorder Toolkit Training

Key Concepts for Primary Care Providers

Audience: Primary Care Providers in Medical Treatment Facilities

DVBIC Defense and Veterans Brain Injury Center
DHCC
National Center for Telehealth & Technology

Key Training Objectives

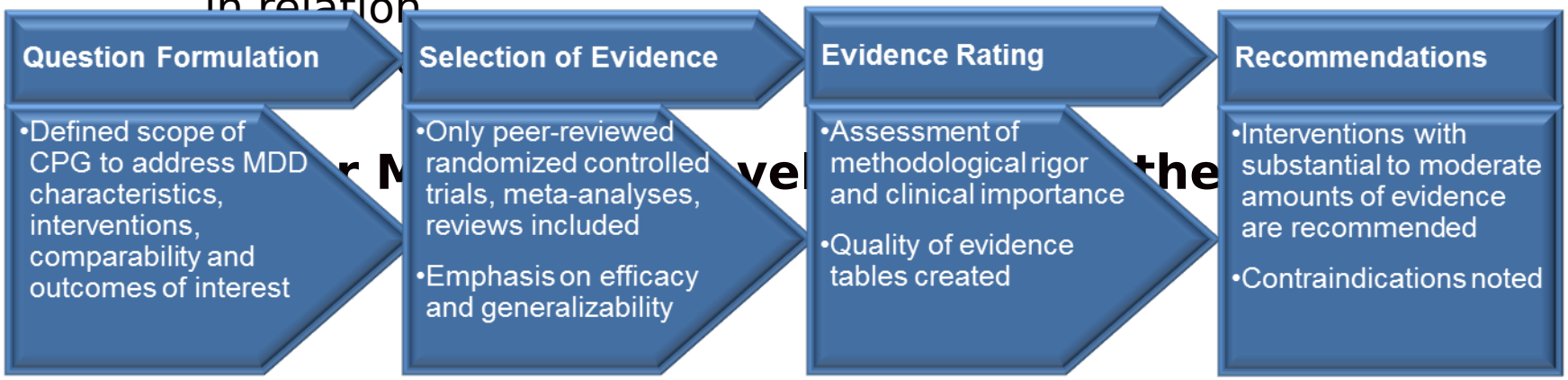
To give primary care providers brief background information on the clinical practice guidelines (CPG) for major depressive disorder (MDD)

To provide primary care providers with an overview of how the tools in the tool kit can be used to efficiently diagnose, assess and treat MDD

Major Depressive Disorder CPG

A clinical practice guideline (CPG) is defined by Veterans Affairs (VA) and the Defense Department (DoD) as:

- Recommendations for the performance or exclusion of specific procedures or services derived through a rigorous methodological approach that includes:
  - Determination of appropriate criteria such as effectiveness, efficacy, population benefit or patient satisfaction
  - Literature review to determine the strength of the evidence in relation



VA/DoD Clinical Practice Guidelines

- Reduce current practice variation and provide facilities with a structured framework to help improve patient outcomes

- Provide evidence-based recommendations to assist providers and their patients in the decision-making process for patients with MDD

- Identify outcome measures to support the development of practice-based evidence that can ultimately be used to improve clinical guidelines

MDD Toolkit

Describes the critical decision points and provides clear and comprehensive evidence-based recommendations incorporating current information and best practices

Provides guidelines for all aspects of care for MDD from screening and assessment to follow-up and monitoring

Includes a variety of reliable tools, questions and simple reference material giving primary care providers the resources they need to address their patients' mental health needs

Can be used in its entirety or in discreet sections depending on what issues arise with each patient

Major Depressive Disorder

- Depression is a major cause of impaired quality of life, reduced productivity and increased mortality in the United States [1]
- People with depression are at increased risk of suicide [1]
- In primary care populations, the prevalence of suicidal ideation is approximately 20-30 percent among depressed patients [1]
- Depression is a significant independent risk factor for both first myocardial infarction and cardiovascular mortality [1]
- The most recent large scale evaluation of the annual economic burden of depression in the United States was estimated to be almost $83.1 billion in the year 2000 [2]

Effect of Major Depressive Disorder on Service Members Returning From Iraq/Afghanistan [3]

- 7-14 percent of combat soldiers returning from Operation Enduring Freedom (OEF) and 8-15 percent returning from Operation Iraqi Freedom (OIF) met the screening criteria for MDD [3]

- The prevalence rates are likely an underestimation of the true occurrence of MDD because many individuals with this disorder never seek treatment. Additionally, primary care providers may not recognize or diagnose MDD [4]

Primary Care Visits and Behavioral Health [5]

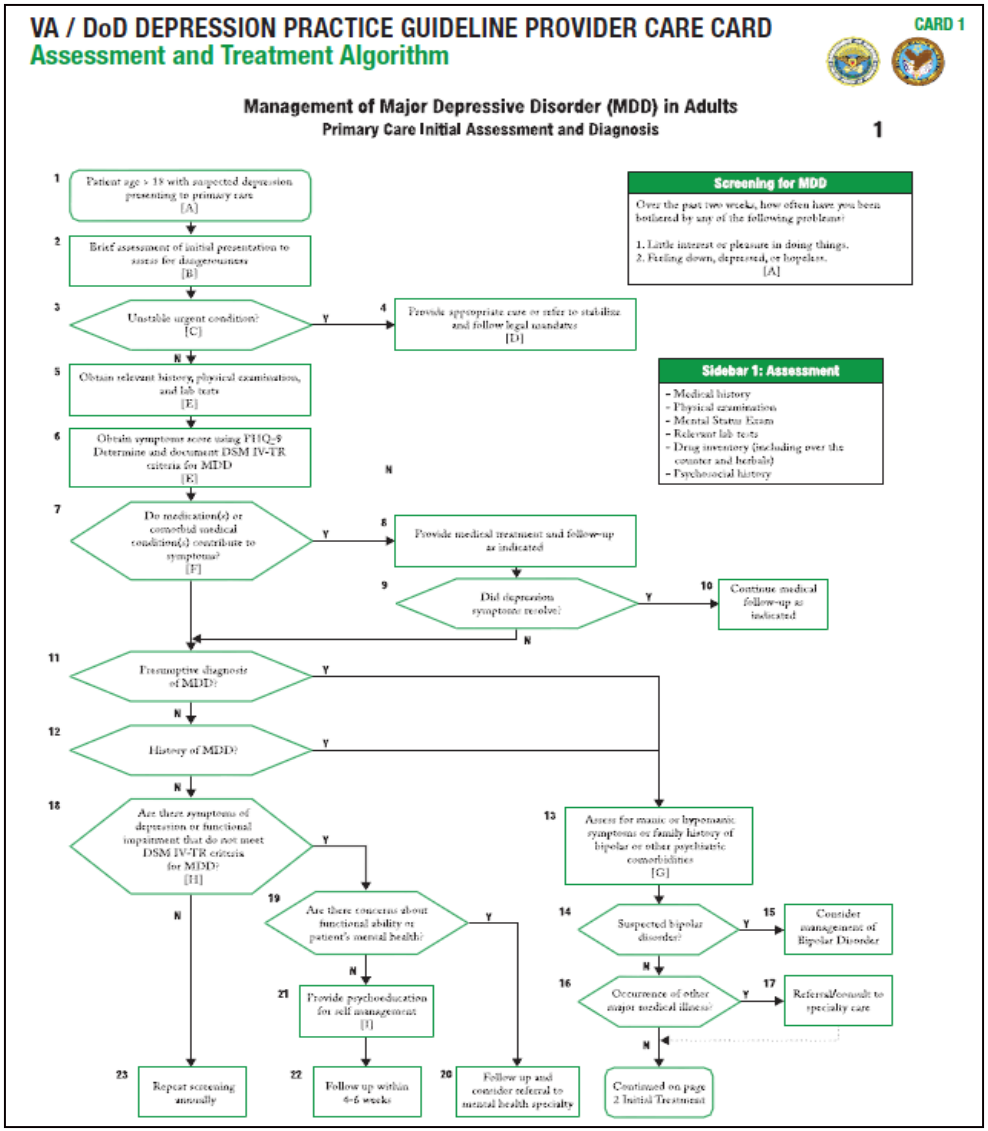
- 42 percent of patients diagnosed with clinical depression were first diagnosed by a primary care physician [6]
- Most depressed patients will receive most or all of their care through primary care physicians [7]
- Primary care providers often lack the time and/or training to help patients manage these problems in evidence-based ways beyond medication prescriptions [5]
- Patients with mental disorders have higher use rates for general medical services and higher related medical costs compared to patients without mental health conditions [6]

Topics Covered in MDD Toolkit

Card	Major Depressive Disorder Topics
1-3	Initial Assessment and Treatment Algorithms
4-8	Identification and Assessment
9-10	Co-morbid/Co-occurring Disorders
11	Criteria for Inpatient Admission
12-18	Patient Education and Treatment Interventions/Referrals
19-20	Treatment Documentation and Performance Metrics
21-31	Medication Tables
32-33	Medications that Cause Depression
34-35	Drug Effects/Side Effects Relative Comparison

Card 1

The VA/DoD CPG Algorithm



Cards 1-3

The VA/DoD CPG Algorithm

- **Sidebar 1: Steps in assessment of MDD**
- Sidebar 2: DSM-IV-TR diagnostic criteria for MDD
- Sidebar 3: Indications for referral to mental health specialty care
- Sidebar 4: Initial treatment strategies for MDD
- Sidebar 5: Assessment and treatment response
- Sidebar 6: Treatment strategies
- Sidebar 7: Indications for consultation or referral to mental health specialty care

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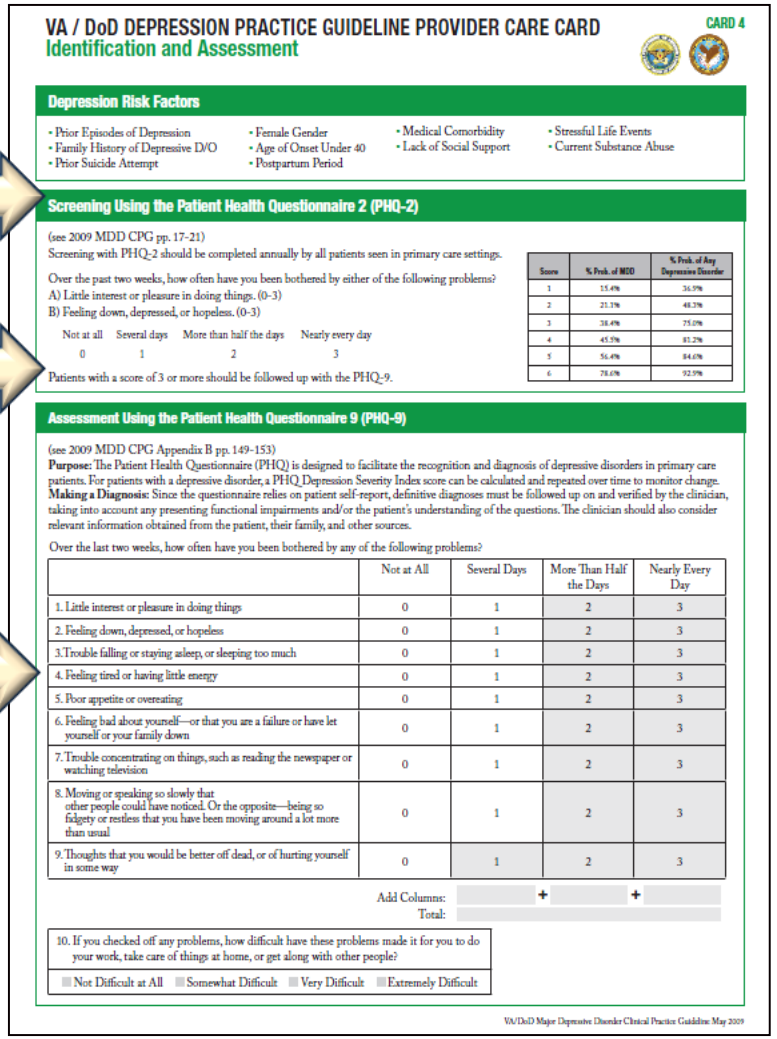
Card 4

The VA/DoD CPG

- Risk factors for MDD (Card 4)
- Patient Health Questionnaire (PHQ)-2 (Card 4)
- PHQ-9 (Card 4-5)



VA / DoD DEPRESSION PRACTICE GUIDELINE PROVIDER CARE CARD
Identification and Assessment

CARD 4

Depression Risk Factors

- Prior Episodes of Depression
- Family History of Depressive D/O
- Prior Suicide Attempt
- Female Gender
- Age of Onset Under 40
- Postpartum Period
- Medical Comorbidity
- Lack of Social Support
- Stressful Life Events
- Current Substance Abuse

Screening Using the Patient Health Questionnaire 2 (PHQ-2)

(see 2009 MDD CPG pp. 17-21)
Screening with PHQ-2 should be completed annually by all patients seen in primary care settings.

Over the past two weeks, how often have you been bothered by either of the following problems?
A) Little interest or pleasure in doing things. (0-3)
B) Feeling down, depressed, or hopeless. (0-3)

Not at all	Several days	More than half the days	Nearly every day
0	1	2	3

Patients with a score of 3 or more should be followed up with the PHQ-9.

Score	% Prob. of MDD	% Prob. of Any Depressive Disorder
1	15.4%	36.9%
2	21.1%	48.3%
3	38.4%	75.0%
4	45.5%	81.2%
5	56.4%	84.6%
6	78.6%	92.9%

Assessment Using the Patient Health Questionnaire 9 (PHQ-9)

(see 2009 MDD CPG Appendix B pp. 149-153)
Purpose: The Patient Health Questionnaire (PHQ) is designed to facilitate the recognition and diagnosis of depressive disorders in primary care patients. For patients with a depressive disorder, a PHQ Depression Severity Index score can be calculated and repeated over time to monitor change.
Making a Diagnosis: Since the questionnaire relies on patient self-report, definitive diagnoses must be followed up on and verified by the clinician, taking into account any presenting functional impairments and/or the patient's understanding of the questions. The clinician should also consider relevant information obtained from the patient, their family, and other sources.

Over the last two weeks, how often have you been bothered by any of the following problems?

	Not at All	Several Days	More Than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3
Add Columns:		+	+	
Total:				

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?			
Not Difficult at All	Somewhat Difficult	Very Difficult	Extremely Difficult

VA/DoD Major Depressive Disorder Clinical Practice Guideline May 2009

Card 4

PHQ-2 Depression Screening Tool

- Administration and scoring takes < 1 minute and can be done by any medical professional or can be handed to patients by administrative staff
- The PHQ-2 includes a reference guide which provides probability of MDD diagnosis based on score
- Patients with a score ≥ 3 should be followed up with the PHQ-9

Card 4

PHQ-2 Depression Screening Tool

PATIENT HEALTH QUESTIONNAIRE 2 (PHQ - 2)

Over the past two weeks, how often have you been bothered by either of the following problems?

A) Little interest or pleasure in doing things. (0-3)
B) Feeling down, depressed, or hopeless. (0-3)

Not at all	Several days	More than half the days	Nearly every day
0	1	2	3

Patients with a score of 3 or greater should be followed up with PHQ-9.

Score	% Prob. of MDD	% Prob. of Any Depressive Disorder
1	15.4%	36.9%
2	21.1%	48.3%
3	38.4%	75.0%
4	45.5%	81.2%
5	56.4%	84.6%
6	78.6%	92.9%

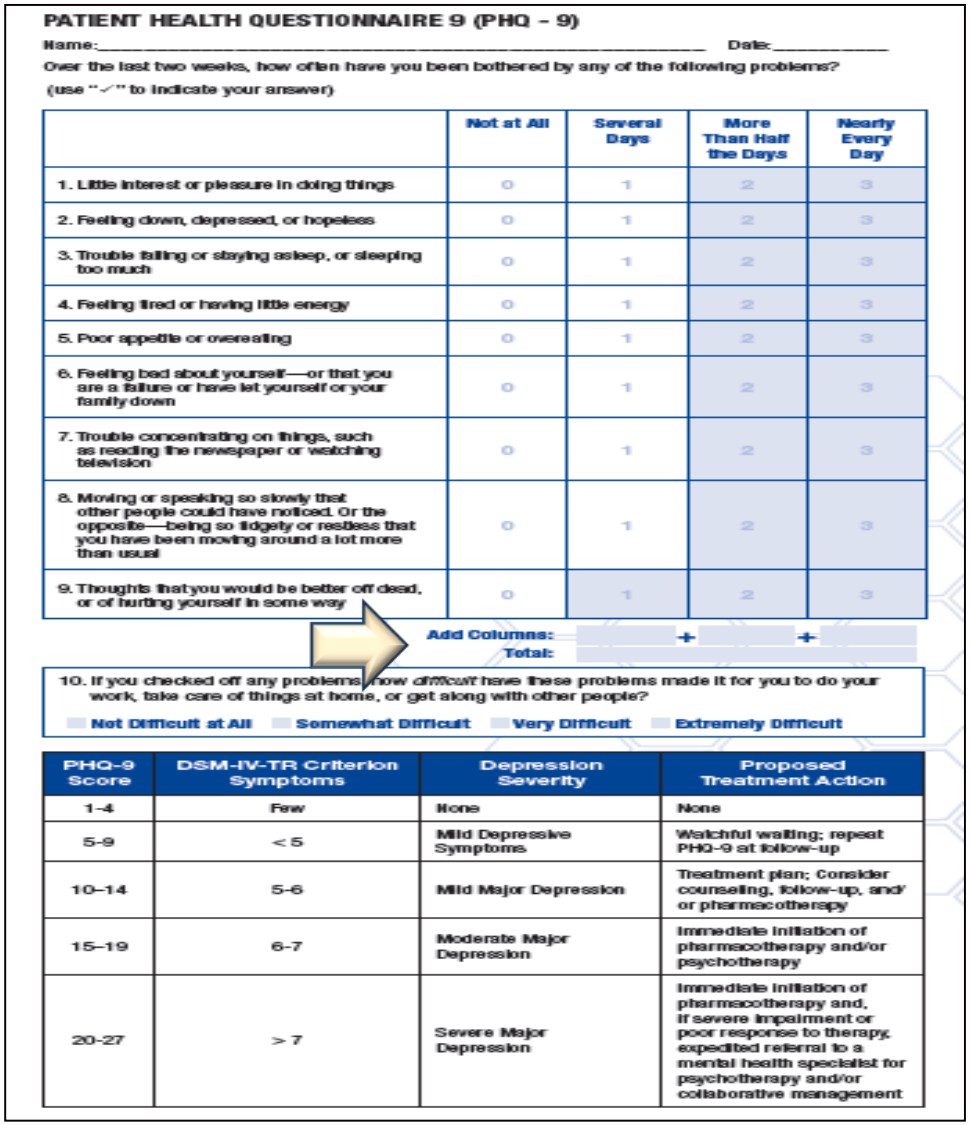
CARDS 4-5

PHQ-9 Assessment Tool

- The PHQ-9 consists of nine questions addressing the frequency of depressive symptoms experienced by the patient
- Administration and scoring time takes approximately five minutes and can be done by any medical professional
- The PHQ-9 includes a guide for interpretation with proposed treatment actions by level of severity
- The PHQ-9 can be used with DSM-IV-TR diagnostic criteria
  to assist in the diagnosis of MDD

CARDS 4-5

PHQ-9 Assessment Tool



PATIENT HEALTH QUESTIONNAIRE 9 (PHQ – 9)

Name:_____ Date:_____

Over the last two weeks, how often have you been bothered by any of the following problems?

(use "✓" to indicate your answer)

	Not at All	Several Days	More Than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3
Add Columns:		+	+	
Total:				

10. If you checked off any problems, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

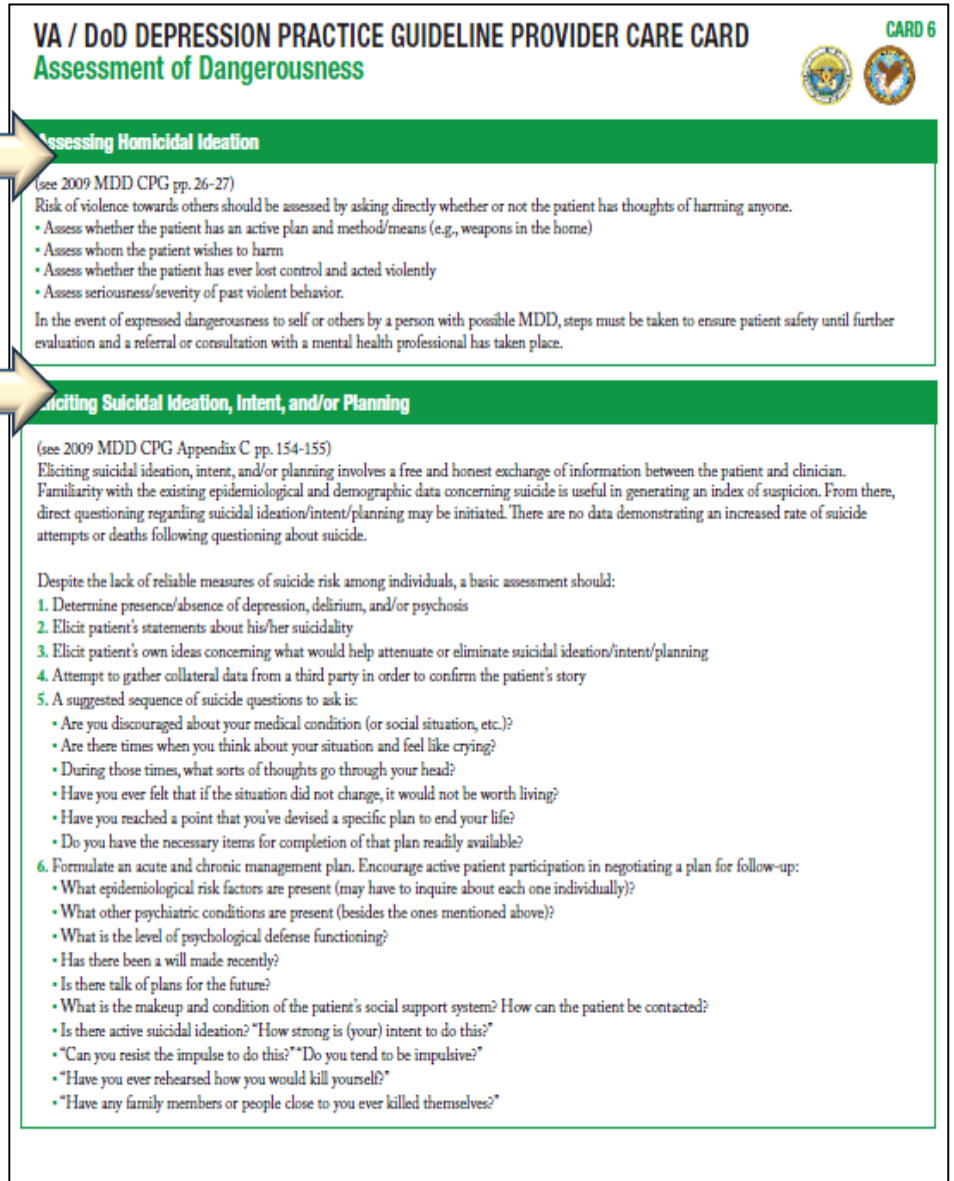
Not Difficult at All | Somewhat Difficult | Very Difficult | Extremely Difficult

PHQ-9 Score	DSM-IV-TR Criterion Symptoms	Depression Severity	Proposed Treatment Action
1–4	Few	None	None
5–9	< 5	Mild Depressive Symptoms	Watchful waiting; repeat PHQ-9 at follow-up
10–14	5–6	Mild Major Depression	Treatment plan; Consider counseling, follow-up, and/ or pharmacotherapy
15–19	6–7	Moderate Major Depression	Immediate initiation of pharmacotherapy and/or psychotherapy
20-27	> 7	Severe Major Depression	Immediate initiation of pharmacotherapy and, If severe impairment or poor response to therapy, expedited referral to a mental health specialist for psychotherapy and/or collaborative management

Card 6

The VA/DoD CPG

- Factors for assessment of homicidal ideation
- Selected direct questions for assessment of suicidal ideation, intent and/or planning



VA / DoD DEPRESSION PRACTICE GUIDELINE PROVIDER CARE CARD

CARD 6

Assessment of Dangerousness

Assessing Homicidal Ideation

(see 2009 MDD CPG pp. 26-27)

Risk of violence towards others should be assessed by asking directly whether or not the patient has thoughts of harming anyone.

- Assess whether the patient has an active plan and method/means (e.g., weapons in the home)
- Assess whom the patient wishes to harm
- Assess whether the patient has ever lost control and acted violently
- Assess seriousness/severity of past violent behavior.

In the event of expressed dangerousness to self or others by a person with possible MDD, steps must be taken to ensure patient safety until further evaluation and a referral or consultation with a mental health professional has taken place.

Eliciting Suicidal Ideation, Intent, and/or Planning

(see 2009 MDD CPG Appendix C pp. 154-155)

Eliciting suicidal ideation, intent, and/or planning involves a free and honest exchange of information between the patient and clinician. Familiarity with the existing epidemiological and demographic data concerning suicide is useful in generating an index of suspicion. From there, direct questioning regarding suicidal ideation/intent/planning may be initiated. There are no data demonstrating an increased rate of suicide attempts or deaths following questioning about suicide.

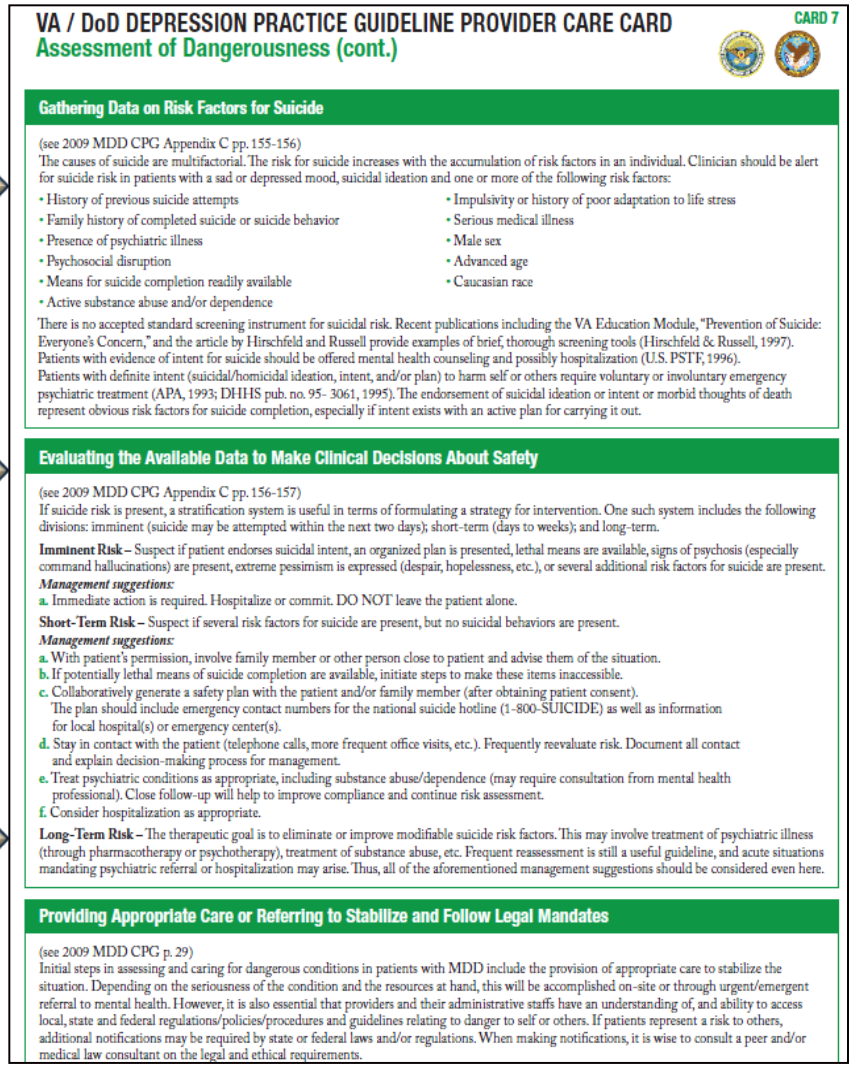
Despite the lack of reliable measures of suicide risk among individuals, a basic assessment should:

1. Determine presence/absence of depression, delirium, and/or psychosis
2. Elicit patient's statements about his/her suicidality
3. Elicit patient's own ideas concerning what would help attenuate or eliminate suicidal ideation/intent/planning
4. Attempt to gather collateral data from a third party in order to confirm the patient's story
5. A suggested sequence of suicide questions to ask is:
   - Are you discouraged about your medical condition (or social situation, etc.)?
   - Are there times when you think about your situation and feel like crying?
   - During those times, what sorts of thoughts go through your head?
   - Have you ever felt that if the situation did not change, it would not be worth living?
   - Have you reached a point that you've devised a specific plan to end your life?
   - Do you have the necessary items for completion of that plan readily available?
6. Formulate an acute and chronic management plan. Encourage active patient participation in negotiating a plan for follow-up:
   - What epidemiological risk factors are present (may have to inquire about each one individually)?
   - What other psychiatric conditions are present (besides the ones mentioned above)?
   - What is the level of psychological defense functioning?
   - Has there been a will made recently?
   - Is there talk of plans for the future?
   - What is the makeup and condition of the patient's social support system? How can the patient be contacted?
   - Is there active suicidal ideation? "How strong is (your) intent to do this?"
   - "Can you resist the impulse to do this?" "Do you tend to be impulsive?"
   - "Have you ever rehearsed how you would kill yourself?"
   - "Have any family members or people close to you ever killed themselves?"

Card 7

The VA/DoD CPG

- Risk factors for suicide
- Guidelines for clinical decisions about safety
- Instructions for referral and for following legal and ethical mandates



VA / DoD DEPRESSION PRACTICE GUIDELINE PROVIDER CARE CARD
CARD 7
Assessment of Dangerousness (cont.)

Gathering Data on Risk Factors for Suicide

(see 2009 MDD CPG Appendix C pp. 155-156)
The causes of suicide are multifactorial. The risk for suicide increases with the accumulation of risk factors in an individual. Clinician should be alert for suicide risk in patients with a sad or depressed mood, suicidal ideation and one or more of the following risk factors:

- History of previous suicide attempts
- Family history of completed suicide or suicide behavior
- Presence of psychiatric illness
- Psychosocial disruption
- Means for suicide completion readily available
- Active substance abuse and/or dependence
- Impulsivity or history of poor adaptation to life stress
- Serious medical illness
- Male sex
- Advanced age
- Caucasian race

There is no accepted standard screening instrument for suicidal risk. Recent publications including the VA Education Module, "Prevention of Suicide: Everyone's Concern," and the article by Hirschfeld and Russell provide examples of brief, thorough screening tools (Hirschfeld & Russell, 1997).
Patients with evidence of intent for suicide should be offered mental health counseling and possibly hospitalization (U.S. PSTF, 1996).
Patients with definite intent (suicidal/homicidal ideation, intent, and/or plan) to harm self or others require voluntary or involuntary emergency psychiatric treatment (APA, 1993; DHHS pub. no. 95- 3061, 1995). The endorsement of suicidal ideation or intent or morbid thoughts of death represent obvious risk factors for suicide completion, especially if intent exists with an active plan for carrying it out.

Evaluating the Available Data to Make Clinical Decisions About Safety

(see 2009 MDD CPG Appendix C pp. 156-157)
If suicide risk is present, a stratification system is useful in terms of formulating a strategy for intervention. One such system includes the following divisions: imminent (suicide may be attempted within the next two days); short-term (days to weeks); and long-term.

Imminent Risk – Suspect if patient endorses suicidal intent, an organized plan is presented, lethal means are available, signs of psychosis (especially command hallucinations) are present, extreme pessimism is expressed (despair, hopelessness, etc.), or several additional risk factors for suicide are present.
Management suggestions:
a. Immediate action is required. Hospitalize or commit. DO NOT leave the patient alone.

Short-Term Risk – Suspect if several risk factors for suicide are present, but no suicidal behaviors are present.
Management suggestions:
a. With patient's permission, involve family member or other person close to patient and advise them of the situation.
b. If potentially lethal means of suicide completion are available, initiate steps to make these items inaccessible.
c. Collaboratively generate a safety plan with the patient and/or family member (after obtaining patient consent). The plan should include emergency contact numbers for the national suicide hotline (1-800-SUICIDE) as well as information for local hospital(s) or emergency center(s).
d. Stay in contact with the patient (telephone calls, more frequent office visits, etc.). Frequently reevaluate risk. Document all contact and explain decision-making process for management.
e. Treat psychiatric conditions as appropriate, including substance abuse/dependence (may require consultation from mental health professional). Close follow-up will help to improve compliance and continue risk assessment.
f. Consider hospitalization as appropriate.

Long-Term Risk – The therapeutic goal is to eliminate or improve modifiable suicide risk factors. This may involve treatment of psychiatric illness (through pharmacotherapy or psychotherapy), treatment of substance abuse, etc. Frequent reassessment is still a useful guideline, and acute situations mandating psychiatric referral or hospitalization may arise. Thus, all of the aforementioned management suggestions should be considered even here.

Providing Appropriate Care or Referring to Stabilize and Follow Legal Mandates

(see 2009 MDD CPG p. 29)
Initial steps in assessing and caring for dangerous conditions in patients with MDD include the provision of appropriate care to stabilize the situation. Depending on the seriousness of the condition and the resources at hand, this will be accomplished on-site or through urgent/emergent referral to mental health. However, it is also essential that providers and their administrative staffs have an understanding of, and ability to access local, state and federal regulations/policies/procedures and guidelines relating to danger to self or others. If patients represent a risk to others, additional notifications may be required by state or federal laws and/or regulations. When making notifications, it is wise to consult a peer and/or medical law consultant on the legal and ethical requirements.

Card 8

The VA/DoD CPG

- Common presentations of MDD in the primary care setting
- Physical conditions that are related to depression
- Diagnostic considerations relevant to the primary care setting

Common Presentations of Depression in Primary Care

- **Multiple Organ Systems** - Symptoms from multiple organ systems, especially neurologic, gastrointestinal, and cardiac that are difficult if not impossible to ascribe to a single medical condition.
- **Emotions** - Patients who are emotionally flat and verbally unproductive, tearful or who are worried or upset out of proportion to the apparent severity of the problem.
- **Visits** - Frequent, often unscheduled, patient-initiated visits to the physician or the emergency room for unclear reasons.
- **Sleep** - Sleep disturbance.
- **Dysfunction** - Patients who have cognitive or emotional dysfunction such as forgetfulness, irritability and loss of motivation or energy.
- **Family History** - A family history of psychiatric illness, suicide or abuse of any kind (sexual, physical, or substance).
- **Recurrence** - Past history of similar episodes or unspecified "breakdowns."
- **"Difficult"** - Patients labeled by health care providers as "difficult" or a "problem."
- **Chronic Pain Syndromes**

Pathologies Related to Depression

(see 2009 MDD CPG pp. 36-38).

Pathology	Disease
Cardiovascular	Coronary Artery Disease, Congestive Heart Failure, Stroke, Vascular Dementias
Chronic Pain Syndrome	Fibromyalgia, Reflex Sympathetic Dystrophy, Low Back Pain (LBP), Chronic Pelvic Pain, Bone or Disease Related Pain
Degenerative	Hearing Loss, Alzheimer's Disease, Parkinson's Disease, Huntington's Disease, Other Neurodegenerative Diseases
Immune	HIV (both primary and infection-related), Multiple Sclerosis, Systemic Lupus Erythematosis (SLE), Sarcoidosis
Metabolic/Endocrine Conditions (includes renal and pulmonary)	Malnutrition, Vitamin Deficiencies, Hypo/Hyperthyroidism, Addison's Disease, Diabetes Mellitus, Hepatic Disease (Cirrhosis), Chronic Obstructive Pulmonary Disease (COPD) or Asthma, Kidney Disease
Neoplasm	Of any kind, especially pancreatic or central nervous system (CNS)
Trauma	Traumatic Brain Injury, Amputation, Burn Injuries

Depression Diagnostic Considerations in Primary Care

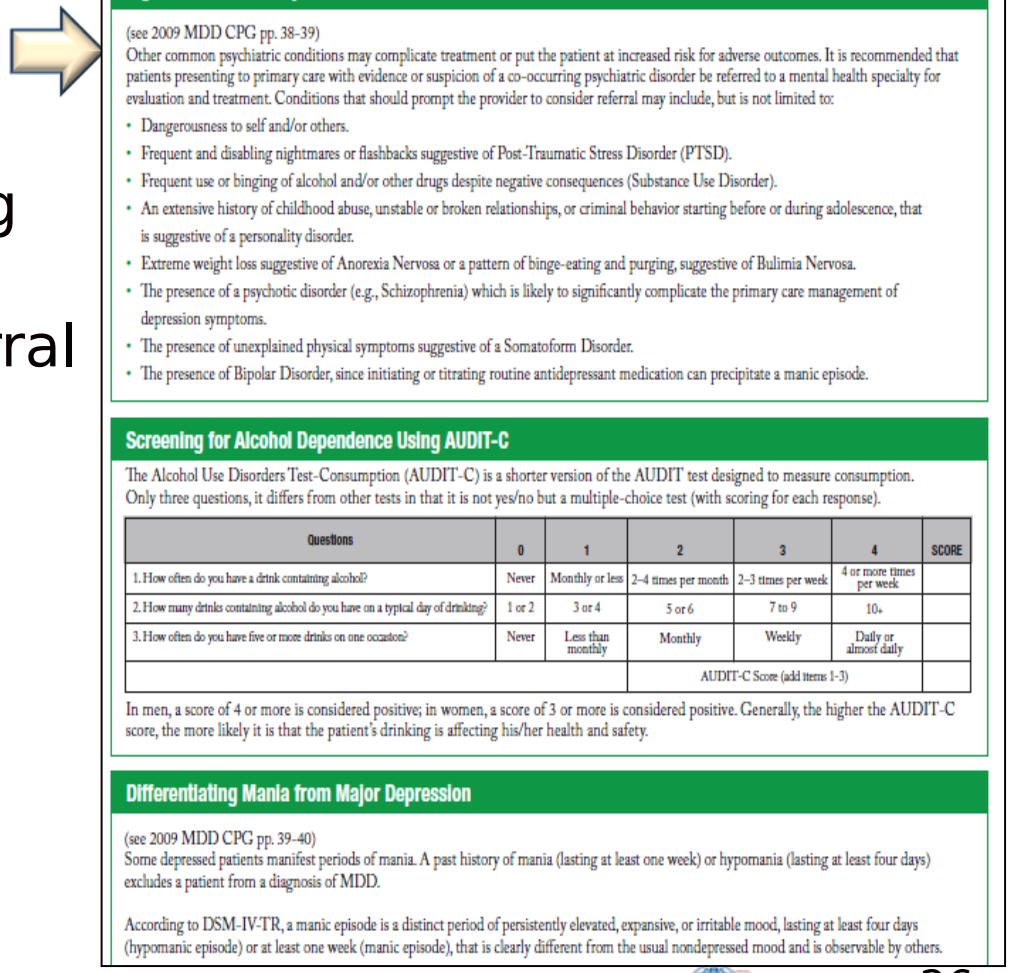
(see 2009 MDD CPG pp. 30-33, 40-41)

- **Symptom-Sign Mismatch** - Suspect depression in cases of many seemingly severe symptoms, a negative physical exam, and an increasingly long list of normal laboratory tests. Caution: maintain the usual vigilance for undiagnosed medical disease.
- **History** - Establish duration of illness, history of prior episodes, family history, history of prior manic/hypomanic episodes, substance abuse and/or other comorbid disorders.
- **Physical Examination** - Screen for anemia, liver/renal dysfunction and thyroid disease, if indicated.
- **Evaluate** - the severity of depressed symptoms, suicidal tendencies and psychotic features (if present).
- **Laboratory Testing** - Laboratory tests have value in ruling out medical conditions that might mimic the symptoms of depression.
- **General Medical Illnesses Associated with Depression** - Myocardial infarction, stroke (particularly left frontal lobe), cancer, major trauma, multiple sclerosis, or any major new diagnosis, particularly if hospitalization is involved.
- **Unexplained Treatment Failure** - Clinical depression can interfere with effective treatment of the primary medical condition, delay recovery and significantly increase morbidity.

Card 9

The VA/DoD CPG

- **Co-occurring conditions**
  - Complicate care
  - If any of the following are present, provider should consider referral
    - PTSD
    - Anorexia
    - Suicidality



VA / DoD DEPRESSION PRACTICE GUIDELINE PROVIDER CARE CARD
CARD 9
Comorbid and Related Conditions

Signs of Comorbid Psychiatric Conditions

(see 2009 MDD CPG pp. 38-39)
Other common psychiatric conditions may complicate treatment or put the patient at increased risk for adverse outcomes. It is recommended that patients presenting to primary care with evidence or suspicion of a co-occurring psychiatric disorder be referred to a mental health specialty for evaluation and treatment. Conditions that should prompt the provider to consider referral may include, but is not limited to:

- Dangerousness to self and/or others.
- Frequent and disabling nightmares or flashbacks suggestive of Post-Traumatic Stress Disorder (PTSD).
- Frequent use or binging of alcohol and/or other drugs despite negative consequences (Substance Use Disorder).
- An extensive history of childhood abuse, unstable or broken relationships, or criminal behavior starting before or during adolescence, that is suggestive of a personality disorder.
- Extreme weight loss suggestive of Anorexia Nervosa or a pattern of binge-eating and purging, suggestive of Bulimia Nervosa.
- The presence of a psychotic disorder (e.g., Schizophrenia) which is likely to significantly complicate the primary care management of depression symptoms.
- The presence of unexplained physical symptoms suggestive of a Somatoform Disorder.
- The presence of Bipolar Disorder, since initiating or titrating routine antidepressant medication can precipitate a manic episode.

Screening for Alcohol Dependence Using AUDIT-C

The Alcohol Use Disorders Test-Consumption (AUDIT-C) is a shorter version of the AUDIT test designed to measure consumption. Only three questions, it differs from other tests in that it is not yes/no but a multiple-choice test (with scoring for each response).

Questions	0	1	2	3	4	SCORE
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2–4 times per month	2–3 times per week	4 or more times per week	
2. How many drinks containing alcohol do you have on a typical day of drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10+	
3. How often do you have five or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
			AUDIT-C Score (add items 1-3)			

In men, a score of 4 or more is considered positive; in women, a score of 3 or more is considered positive. Generally, the higher the AUDIT-C score, the more likely it is that the patient's drinking is affecting his/her health and safety.

Differentiating Mania from Major Depression

(see 2009 MDD CPG pp. 39-40)
Some depressed patients manifest periods of mania. A past history of mania (lasting at least one week) or hypomania (lasting at least four days) excludes a patient from a diagnosis of MDD.

According to DSM-IV-TR, a manic episode is a distinct period of persistently elevated, expansive, or irritable mood, lasting at least four days (hypomanic episode) or at least one week (manic episode), that is clearly different from the usual nondepressed mood and is observable by others.

Card 9

The VA/DoD CPG and AUDIT-C

- The Alcohol Use Disorders Test- Consumption (AUDIT-C) is a 3-item alcohol screen designed to measure alcohol consumption and identify people who are hazardous drinkers
- In general, the higher the AUDIT-C score, the more likely it is that the patient's drinking is affecting his/her health and safety
- In men, a score ≥ 4 is considered positive, identifying hazardous drinking or active alcohol use disorders
- In women, a score ≥ 3 is considered positive (same as above)

Card 9

The VA/DoD CPG and AUDIT-C

Scoring AUDIT-C

Question	0 points	1 point	2 points	3 points	4 points
1. How often did you have a drink containing alcohol in the past year?	☐ Never	☐ Monthly or less	☐ 2 to 4 times per month	☐ 2 to 3 times per week	☐ 4 or more times per week
2. On days in the past year when you drank alcohol how many drinks did you typically drink?	☐ 1 or 2	☐ 3 or 4	☐ 5 to 6	☐ 7 to 9	☐ 10 or more
3. How often do you have 6 or more drinks on an occasion in the past year?	☐ Never	☐ Less than Monthly	☐ Monthly	☐ Weekly	☐ Daily or almost daily

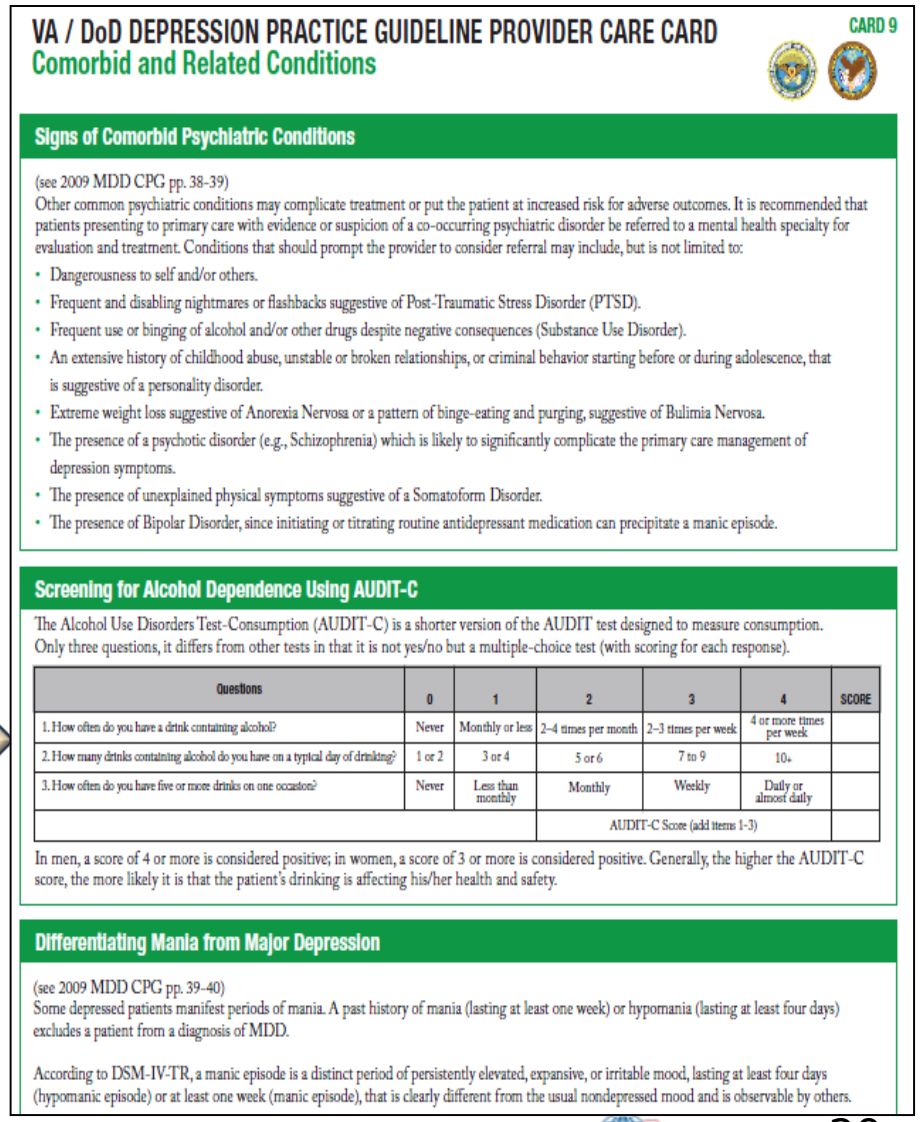
When the Audit-C is administered by self-report add a "0 drinks" response option to question #2 (0 points based on validations studies). In addition, it is valid to input responses of 0 points to questions #2-3 for patients who indicate "never" in response to question #1 (past year non-drinkers).

The minimum score (for non-drinkers) is 0 and the maximum possible score is 12. **Consider a screen positive for unhealthy alcohol use if AUDIT-C score is ≥ 4 points for men OR ≥ 3 points for women.**

Card 9

The VA/DoD CPG

- **Differentiating MDD from Mania/Bipolar Disorder**
  - Definitions of Hypomanic and Manic episodes
  - DSM-IV-TR Diagnostic Criteria for mania
  - Referral Indications



VA / DoD DEPRESSION PRACTICE GUIDELINE PROVIDER CARE CARD
CARD 9
Comorbid and Related Conditions

Signs of Comorbid Psychiatric Conditions

(see 2009 MDD CPG pp. 38-39)
Other common psychiatric conditions may complicate treatment or put the patient at increased risk for adverse outcomes. It is recommended that patients presenting to primary care with evidence or suspicion of a co-occurring psychiatric disorder be referred to a mental health specialty for evaluation and treatment. Conditions that should prompt the provider to consider referral may include, but is not limited to:

- Dangerousness to self and/or others.
- Frequent and disabling nightmares or flashbacks suggestive of Post-Traumatic Stress Disorder (PTSD).
- Frequent use or binging of alcohol and/or other drugs despite negative consequences (Substance Use Disorder).
- An extensive history of childhood abuse, unstable or broken relationships, or criminal behavior starting before or during adolescence, that is suggestive of a personality disorder.
- Extreme weight loss suggestive of Anorexia Nervosa or a pattern of binge-eating and purging, suggestive of Bulimia Nervosa.
- The presence of a psychotic disorder (e.g., Schizophrenia) which is likely to significantly complicate the primary care management of depression symptoms.
- The presence of unexplained physical symptoms suggestive of a Somatoform Disorder.
- The presence of Bipolar Disorder, since initiating or titrating routine antidepressant medication can precipitate a manic episode.

Screening for Alcohol Dependence Using AUDIT-C

The Alcohol Use Disorders Test-Consumption (AUDIT-C) is a shorter version of the AUDIT test designed to measure consumption. Only three questions, it differs from other tests in that it is not yes/no but a multiple-choice test (with scoring for each response).

Questions	0	1	2	3	4	SCORE
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2–4 times per month	2–3 times per week	4 or more times per week	
2. How many drinks containing alcohol do you have on a typical day of drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10+	
3. How often do you have five or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
			AUDIT-C Score (add items 1-3)			

In men, a score of 4 or more is considered positive; in women, a score of 3 or more is considered positive. Generally, the higher the AUDIT-C score, the more likely it is that the patient's drinking is affecting his/her health and safety.

Differentiating Mania from Major Depression

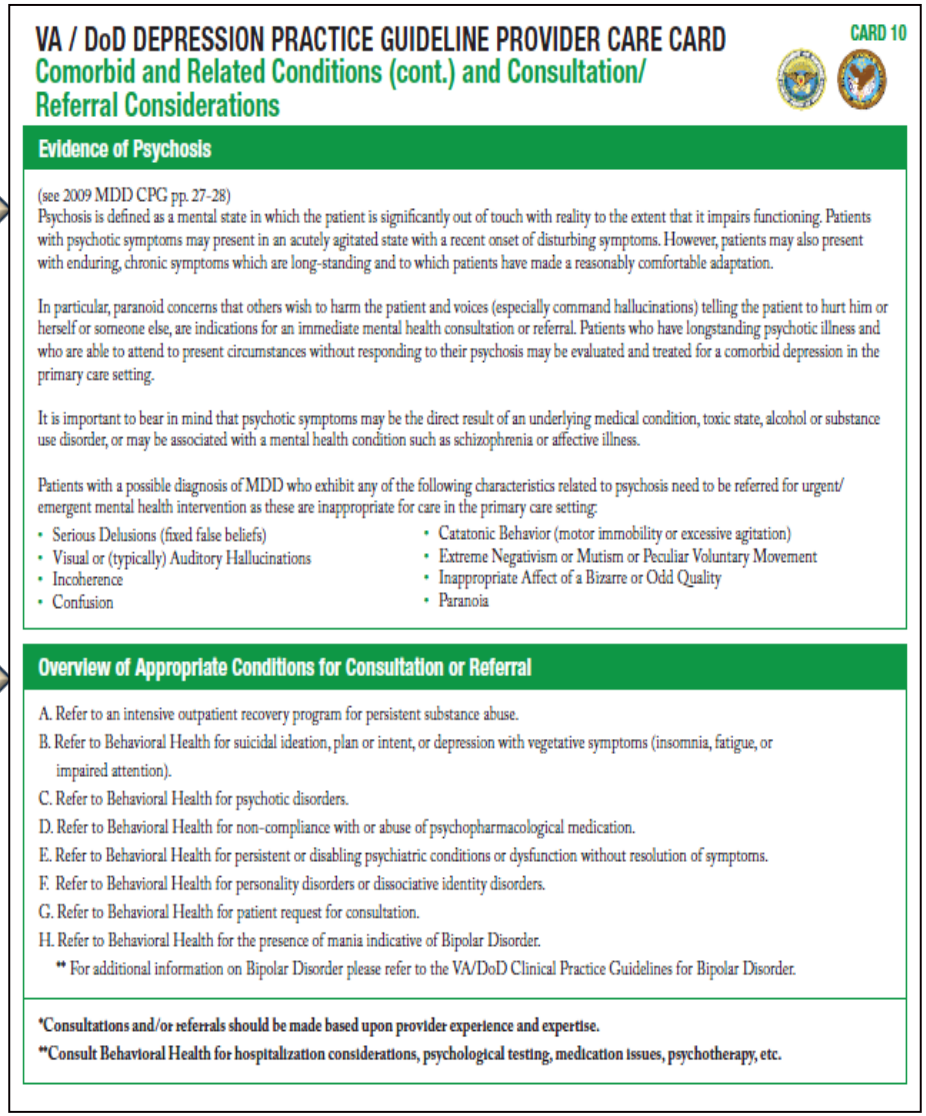
(see 2009 MDD CPG pp. 39-40)
Some depressed patients manifest periods of mania. A past history of mania (lasting at least one week) or hypomania (lasting at least four days) excludes a patient from a diagnosis of MDD.

According to DSM-IV-TR, a manic episode is a distinct period of persistently elevated, expansive, or irritable mood, lasting at least four days (hypomanic episode) or at least one week (manic episode), that is clearly different from the usual nondepressed mood and is observable by others.

Card 10

The VA/DoD CPG

- **Overview of psychosis**
  - Considerations for evaluation
  - Guidance on what symptoms indicate a need for urgent referral
- **Considerations for consultation or referral**
  - Visual or auditory hallucinations
  - Non-compliance or abuse of psychopharmalogical medications
  - Suicidality
  - Presence of mania



VA / DoD DEPRESSION PRACTICE GUIDELINE PROVIDER CARE CARD

CARD 10

Comorbid and Related Conditions (cont.) and Consultation/ Referral Considerations

Evidence of Psychosis

(see 2009 MDD CPG pp. 27-28)

Psychosis is defined as a mental state in which the patient is significantly out of touch with reality to the extent that it impairs functioning. Patients with psychotic symptoms may present in an acutely agitated state with a recent onset of disturbing symptoms. However, patients may also present with enduring, chronic symptoms which are long-standing and to which patients have made a reasonably comfortable adaptation.

In particular, paranoid concerns that others wish to harm the patient and voices (especially command hallucinations) telling the patient to hurt him or herself or someone else, are indications for an immediate mental health consultation or referral. Patients who have longstanding psychotic illness and who are able to attend to present circumstances without responding to their psychosis may be evaluated and treated for a comorbid depression in the primary care setting.

It is important to bear in mind that psychotic symptoms may be the direct result of an underlying medical condition, toxic state, alcohol or substance use disorder, or may be associated with a mental health condition such as schizophrenia or affective illness.

Patients with a possible diagnosis of MDD who exhibit any of the following characteristics related to psychosis need to be referred for urgent/ emergent mental health intervention as these are inappropriate for care in the primary care setting:

- Serious Delusions (fixed false beliefs)
- Visual or (typically) Auditory Hallucinations
- Incoherence
- Confusion
- Catatonic Behavior (motor immobility or excessive agitation)
- Extreme Negativism or Mutism or Peculiar Voluntary Movement
- Inappropriate Affect of a Bizarre or Odd Quality
- Paranoia

Overview of Appropriate Conditions for Consultation or Referral

A. Refer to an intensive outpatient recovery program for persistent substance abuse.

B. Refer to Behavioral Health for suicidal ideation, plan or intent, or depression with vegetative symptoms (insomnia, fatigue, or impaired attention).

C. Refer to Behavioral Health for psychotic disorders.

D. Refer to Behavioral Health for non-compliance with or abuse of psychopharmacological medication.

E. Refer to Behavioral Health for persistent or disabling psychiatric conditions or dysfunction without resolution of symptoms.

F. Refer to Behavioral Health for personality disorders or dissociative identity disorders.

G. Refer to Behavioral Health for patient request for consultation.

H. Refer to Behavioral Health for the presence of mania indicative of Bipolar Disorder.

** For additional information on Bipolar Disorder please refer to the VA/DoD Clinical Practice Guidelines for Bipolar Disorder.

*Consultations and/or referrals should be made based upon provider experience and expertise.

**Consult Behavioral Health for hospitalization considerations, psychological testing, medication issues, psychotherapy, etc.

Card 11

The VA/DoD CPG

Inpatient admission is indicated if the criteria in Section A are met, and the criterion for B, C or D is also met

A ***DSM-IV-TR diagnosis is present and there is evidence that there is a significant functional impairment or subjective suffering***

B ***Patient is a danger to himself/herself***

C ***Patient is a danger to others as a result of a mental disorder***

D ***The patient has a serious mental disorder causing significant impairment of functioning that would benefit from the intensity of acute treatment***

Card 12

The VA/DoD CPG

Overview of Treatment Strategies

Treatment Strategies (see 2009 MDD CPG p. 51-60)

	LEVEL	PHQ TOTAL SCORE	FUNCTIONAL IMPAIRMENT	INITIAL TREATMENT STRATEGIES*
Severity	Mild	5-14	Mild	Watchful waiting, supportive counseling, self-management (e.g., exercise – see self-management worksheet on cards 14 and 15); if no improvement after one or more months, consider use of an antidepressant or brief psychological counseling.
	Moderate	15-19	Moderate	Start with combination of medications and psychotherapy.
	Severe	≥20	Severe	Combination of antidepressants and psychotherapy, or multiple drug therapy.
Modifiers	Complicated	Co-occurring PTSD, SUD, mania, or significant social stressors		Start with combination of medications and somatic interventions.
	Chronicity	> 2 years of symptomatology despite treatment		For mild – start with monotherapy of either antidepressants or psychotherapy, or a combination of both. For Mod/Severe - combination of antidepressants and psychotherapy or multiple drug therapy.

*Initial Treatment strategy options include:
1. Psychoeducation and self-management (provided to all MDD patients)
2. Watchful waiting
3. Monotherapy (psychotherapy or pharmacotherapy)
4. Combination psychotherapy and antidepressants
5. Treatment of complex patients
6. Somatic treatment
7. Inpatient and residential

Card 12

The VA/DoD CPG

Psychoeducation

Psychoeducation
(see 2009 MDD CPG pp. 51-55)

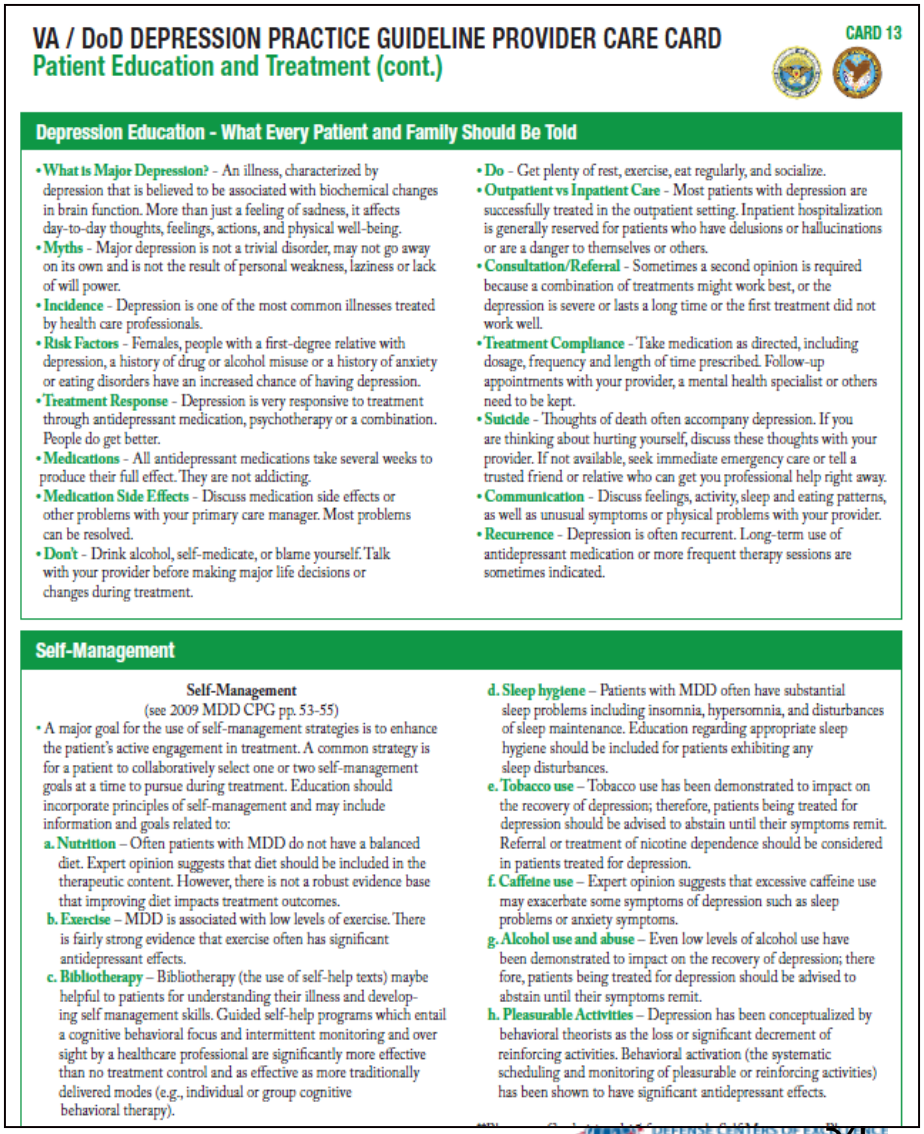
- Psychoeducation should be provided for individuals with depression at all levels of severity and in all care settings and should be provided both verbally and with written educational materials.
- There should be education on the nature of depression and its treatment options and should include the following:
  - a. Depression is a medical illness, not a character defect
  - b. Education on the causes, symptoms, and natural history of major depression
  - c. Treatment is often effective and is the rule rather than the exception
  - d. The goal of treatment is complete remission; this may require several treatment trials
  - e. Treatment of depression can lead to decreased physical disability and longer life
  - f. Education about various treatment options, including the advantages and disadvantages of each, side effects, what to expect during treatment, and the length of treatment
- When antidepressant pharmacotherapy is used, the following key messages should be given to enhance adherence to medication: [B]
  - a. Side effects often precede therapeutic benefit, but typically recede over time while benefits increase
  - b. A slight increase in suicidal ideation in the first month may occur and patients should contact their provider if this does occur.
  - c. Successful treatment often entails medication and/or dosage adjustments in order to maximize response while minimizing side effects
  - d. Most people need to be on medication for at least six to 12 months after adequate response
  - e. It usually takes two to six weeks before improvements are seen
  - f. Continue to take the medication even after feeling better
  - g. Do not discontinue taking medications without first discussing with your provider
- Education focused on treatment adherence should focus on the following:
  - a. Education on the risk of relapse in general; essentially, that relapse risk is high, particularly as the frequency of prior episodes increases
  - b. Education on how to monitor symptoms and side effects
  - c. Education on early signs and symptoms of relapse or recurrence, along with encouragement to seek treatment early in the event these signs or symptoms occur.
- Psychoeducational strategies should be incorporated into structured and organized treatment protocols, which entail structured systematic monitoring of treatment adherence and response and self-management strategies.

Card 13

The VA/DoD CPG

- **Depression education for patients and their families**

- **Self-management topics including:**
  - Nutrition
  - Exercise
  - Bibliotherapy
  - Sleep Hygiene
  - Alcohol use



VA / DoD DEPRESSION PRACTICE GUIDELINE PROVIDER CARE CARD
Patient Education and Treatment (cont.)

CARD 13

Depression Education - What Every Patient and Family Should Be Told

- **What is Major Depression?** - An illness, characterized by depression that is believed to be associated with biochemical changes in brain function. More than just a feeling of sadness, it affects day-to-day thoughts, feelings, actions, and physical well-being.
- **Myths** - Major depression is not a trivial disorder, may not go away on its own and is not the result of personal weakness, laziness or lack of will power.
- **Incidence** - Depression is one of the most common illnesses treated by health care professionals.
- **Risk Factors** - Females, people with a first-degree relative with depression, a history of drug or alcohol misuse or a history of anxiety or eating disorders have an increased chance of having depression.
- **Treatment Response** - Depression is very responsive to treatment through antidepressant medication, psychotherapy or a combination. People do get better.
- **Medications** - All antidepressant medications take several weeks to produce their full effect. They are not addicting.
- **Medication Side Effects** - Discuss medication side effects or other problems with your primary care manager. Most problems can be resolved.
- **Don't** - Drink alcohol, self-medicate, or blame yourself. Talk with your provider before making major life decisions or changes during treatment.
- **Do** - Get plenty of rest, exercise, eat regularly, and socialize.
- **Outpatient vs Inpatient Care** - Most patients with depression are successfully treated in the outpatient setting. Inpatient hospitalization is generally reserved for patients who have delusions or hallucinations or are a danger to themselves or others.
- **Consultation/Referral** - Sometimes a second opinion is required because a combination of treatments might work best, or the depression is severe or lasts a long time or the first treatment did not work well.
- **Treatment Compliance** - Take medication as directed, including dosage, frequency and length of time prescribed. Follow-up appointments with your provider, a mental health specialist or others need to be kept.
- **Suicide** - Thoughts of death often accompany depression. If you are thinking about hurting yourself, discuss these thoughts with your provider. If not available, seek immediate emergency care or tell a trusted friend or relative who can get you professional help right away.
- **Communication** - Discuss feelings, activity, sleep and eating patterns, as well as unusual symptoms or physical problems with your provider.
- **Recurrence** - Depression is often recurrent. Long-term use of antidepressant medication or more frequent therapy sessions are sometimes indicated.

Self-Management

Self-Management
(see 2009 MDD CPG pp. 53-55)

- A major goal for the use of self-management strategies is to enhance the patient's active engagement in treatment. A common strategy is for a patient to collaboratively select one or two self-management goals at a time to pursue during treatment. Education should incorporate principles of self-management and may include information and goals related to:

a. **Nutrition** – Often patients with MDD do not have a balanced diet. Expert opinion suggests that diet should be included in the therapeutic content. However, there is not a robust evidence base that improving diet impacts treatment outcomes.

b. **Exercise** – MDD is associated with low levels of exercise. There is fairly strong evidence that exercise often has significant antidepressant effects.

c. **Bibliotherapy** – Bibliotherapy (the use of self-help texts) maybe helpful to patients for understanding their illness and develop-ing self management skills. Guided self-help programs which entail a cognitive behavioral focus and intermittent monitoring and over sight by a healthcare professional are significantly more effective than no treatment control and as effective as more traditionally delivered modes (e.g., individual or group cognitive behavioral therapy).

d. **Sleep hygiene** – Patients with MDD often have substantial sleep problems including insomnia, hypersomnia, and disturbances of sleep maintenance. Education regarding appropriate sleep hygiene should be included for patients exhibiting any sleep disturbances.

e. **Tobacco use** – Tobacco use has been demonstrated to impact on the recovery of depression; therefore, patients being treated for depression should be advised to abstain until their symptoms remit. Referral or treatment of nicotine dependence should be considered in patients treated for depression.

f. **Caffeine use** – Expert opinion suggests that excessive caffeine use may exacerbate some symptoms of depression such as sleep problems or anxiety symptoms.

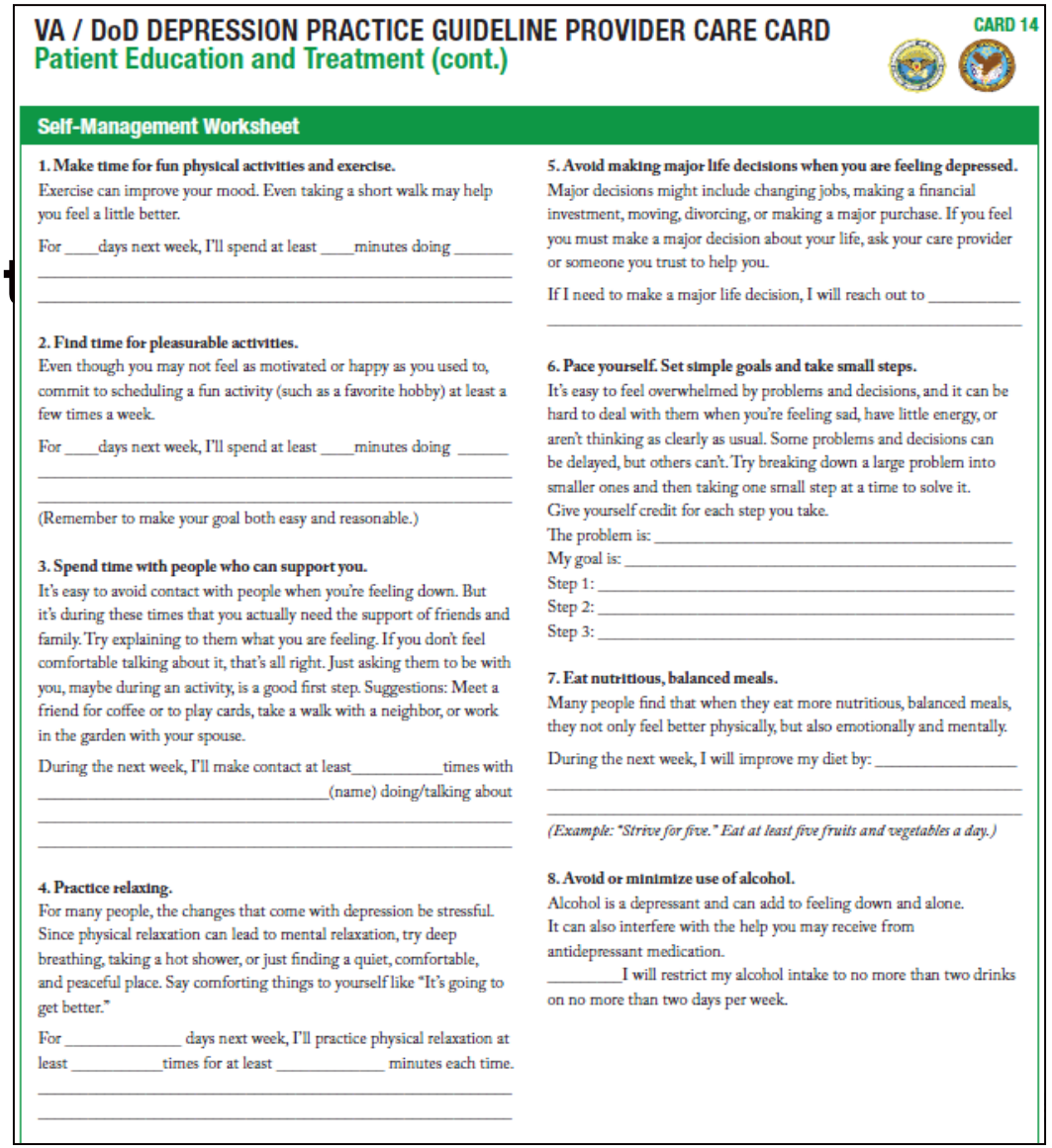
g. **Alcohol use and abuse** – Even low levels of alcohol use have been demonstrated to impact on the recovery of depression; there fore, patients being treated for depression should be advised to abstain until their symptoms remit.

h. **Pleasurable Activities** – Depression has been conceptualized by behavioral theorists as the loss or significant decrement of reinforcing activities. Behavioral activation (the systematic scheduling and monitoring of pleasurable or reinforcing activities) has been shown to have significant antidepressant effects.

Cards 14-15

The VA/DoD CPG

- **Sample patient worksheets for self-management**
  - (Cards 14-15)



VA / DoD DEPRESSION PRACTICE GUIDELINE PROVIDER CARE CARD

CARD 14

Patient Education and Treatment (cont.)

Self-Management Worksheet

1. Make time for fun physical activities and exercise.
Exercise can improve your mood. Even taking a short walk may help you feel a little better.

For ____days next week, I'll spend at least ____minutes doing _____
_____
_____

2. Find time for pleasurable activities.
Even though you may not feel as motivated or happy as you used to, commit to scheduling a fun activity (such as a favorite hobby) at least a few times a week.

For ____days next week, I'll spend at least ____minutes doing _____
_____
_____
(Remember to make your goal both easy and reasonable.)

3. Spend time with people who can support you.
It's easy to avoid contact with people when you're feeling down. But it's during these times that you actually need the support of friends and family. Try explaining to them what you are feeling. If you don't feel comfortable talking about it, that's all right. Just asking them to be with you, maybe during an activity, is a good first step. Suggestions: Meet a friend for coffee or to play cards, take a walk with a neighbor, or work in the garden with your spouse.

During the next week, I'll make contact at least_____times with _____(name) doing/talking about
_____
_____

4. Practice relaxing.
For many people, the changes that come with depression be stressful. Since physical relaxation can lead to mental relaxation, try deep breathing, taking a hot shower, or just finding a quiet, comfortable, and peaceful place. Say comforting things to yourself like "It's going to get better."

For _____ days next week, I'll practice physical relaxation at least _____times for at least _____ minutes each time.
_____
_____

5. Avoid making major life decisions when you are feeling depressed.
Major decisions might include changing jobs, making a financial investment, moving, divorcing, or making a major purchase. If you feel you must make a major decision about your life, ask your care provider or someone you trust to help you.

If I need to make a major life decision, I will reach out to _____
_____

6. Pace yourself. Set simple goals and take small steps.
It's easy to feel overwhelmed by problems and decisions, and it can be hard to deal with them when you're feeling sad, have little energy, or aren't thinking as clearly as usual. Some problems and decisions can be delayed, but others can't. Try breaking down a large problem into smaller ones and then taking one small step at a time to solve it. Give yourself credit for each step you take.
The problem is: _____
My goal is: _____
Step 1: _____
Step 2: _____
Step 3: _____

7. Eat nutritious, balanced meals.
Many people find that when they eat more nutritious, balanced meals, they not only feel better physically, but also emotionally and mentally.

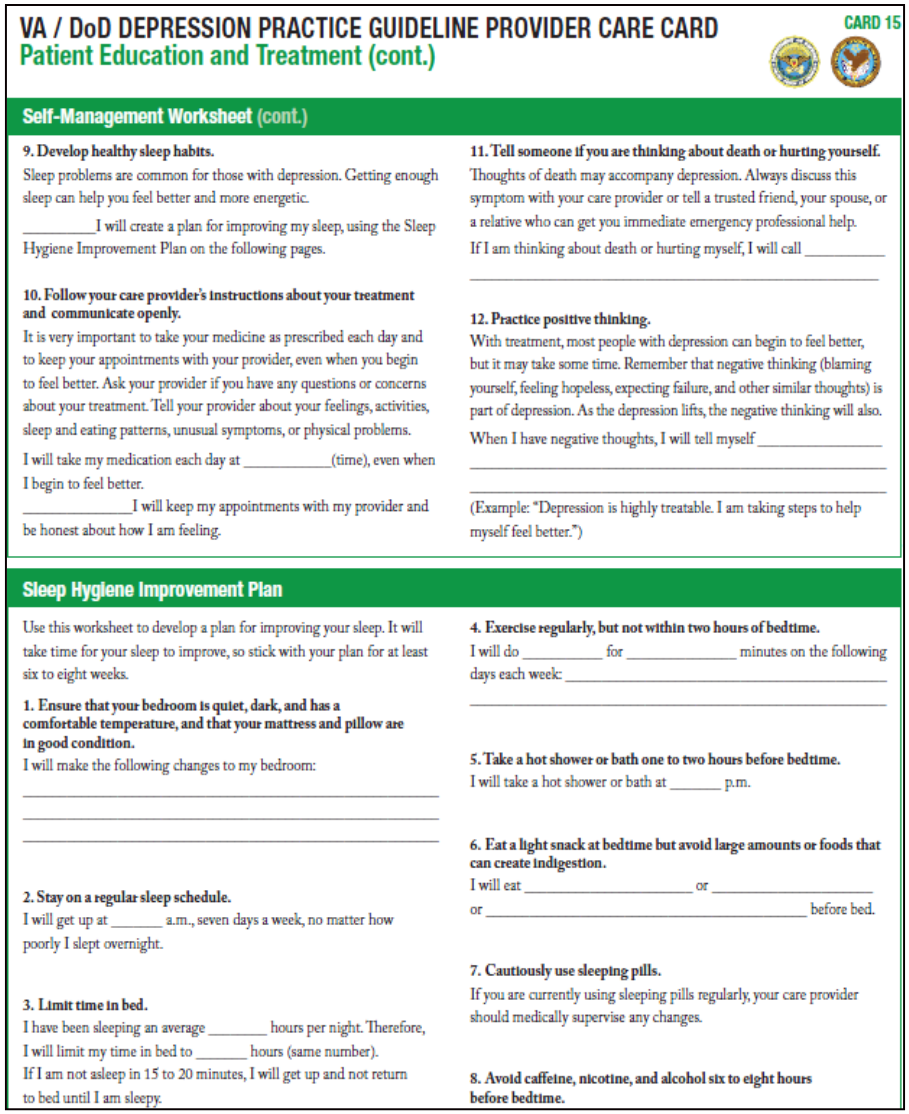
During the next week, I will improve my diet by: _____
_____
_____
(Example: "Strive for five." Eat at least five fruits and vegetables a day.)

8. Avoid or minimize use of alcohol.
Alcohol is a depressant and can add to feeling down and alone. It can also interfere with the help you may receive from antidepressant medication.
_____I will restrict my alcohol intake to no more than two drinks on no more than two days per week.

Cards 14-15

The VA/DoD CPG

- **Sample patient worksheets for self-management**
  - (Cards 14-15)
- **Sleep hygiene improvement plan**
  - (Card 15)



VA / DoD DEPRESSION PRACTICE GUIDELINE PROVIDER CARE CARD
Patient Education and Treatment (cont.)

CARD 15

Self-Management Worksheet (cont.)

9. Develop healthy sleep habits.
Sleep problems are common for those with depression. Getting enough sleep can help you feel better and more energetic.

_____I will create a plan for improving my sleep, using the Sleep Hygiene Improvement Plan on the following pages.

10. Follow your care provider's instructions about your treatment and communicate openly.
It is very important to take your medicine as prescribed each day and to keep your appointments with your provider, even when you begin to feel better. Ask your provider if you have any questions or concerns about your treatment. Tell your provider about your feelings, activities, sleep and eating patterns, unusual symptoms, or physical problems.

I will take my medication each day at _____(time), even when I begin to feel better.

_____I will keep my appointments with my provider and be honest about how I am feeling.

11. Tell someone if you are thinking about death or hurting yourself.
Thoughts of death may accompany depression. Always discuss this symptom with your care provider or tell a trusted friend, your spouse, or a relative who can get you immediate emergency professional help.

If I am thinking about death or hurting myself, I will call _____

_____

12. Practice positive thinking.
With treatment, most people with depression can begin to feel better, but it may take some time. Remember that negative thinking (blaming yourself, feeling hopeless, expecting failure, and other similar thoughts) is part of depression. As the depression lifts, the negative thinking will also.

When I have negative thoughts, I will tell myself _____

_____

_____

(Example: "Depression is highly treatable. I am taking steps to help myself feel better.")

Sleep Hygiene Improvement Plan

Use this worksheet to develop a plan for improving your sleep. It will take time for your sleep to improve, so stick with your plan for at least six to eight weeks.

1. Ensure that your bedroom is quiet, dark, and has a comfortable temperature, and that your mattress and pillow are in good condition.
I will make the following changes to my bedroom:

_____

_____

_____

2. Stay on a regular sleep schedule.
I will get up at _____ a.m., seven days a week, no matter how poorly I slept overnight.

3. Limit time in bed.
I have been sleeping an average _____ hours per night. Therefore, I will limit my time in bed to _____ hours (same number).
If I am not asleep in 15 to 20 minutes, I will get up and not return to bed until I am sleepy.

4. Exercise regularly, but not within two hours of bedtime.
I will do _____ for _____ minutes on the following days each week: _____

_____

5. Take a hot shower or bath one to two hours before bedtime.
I will take a hot shower or bath at _____ p.m.

6. Eat a light snack at bedtime but avoid large amounts or foods that can create indigestion.
I will eat _____ or _____
or _____ before bed.

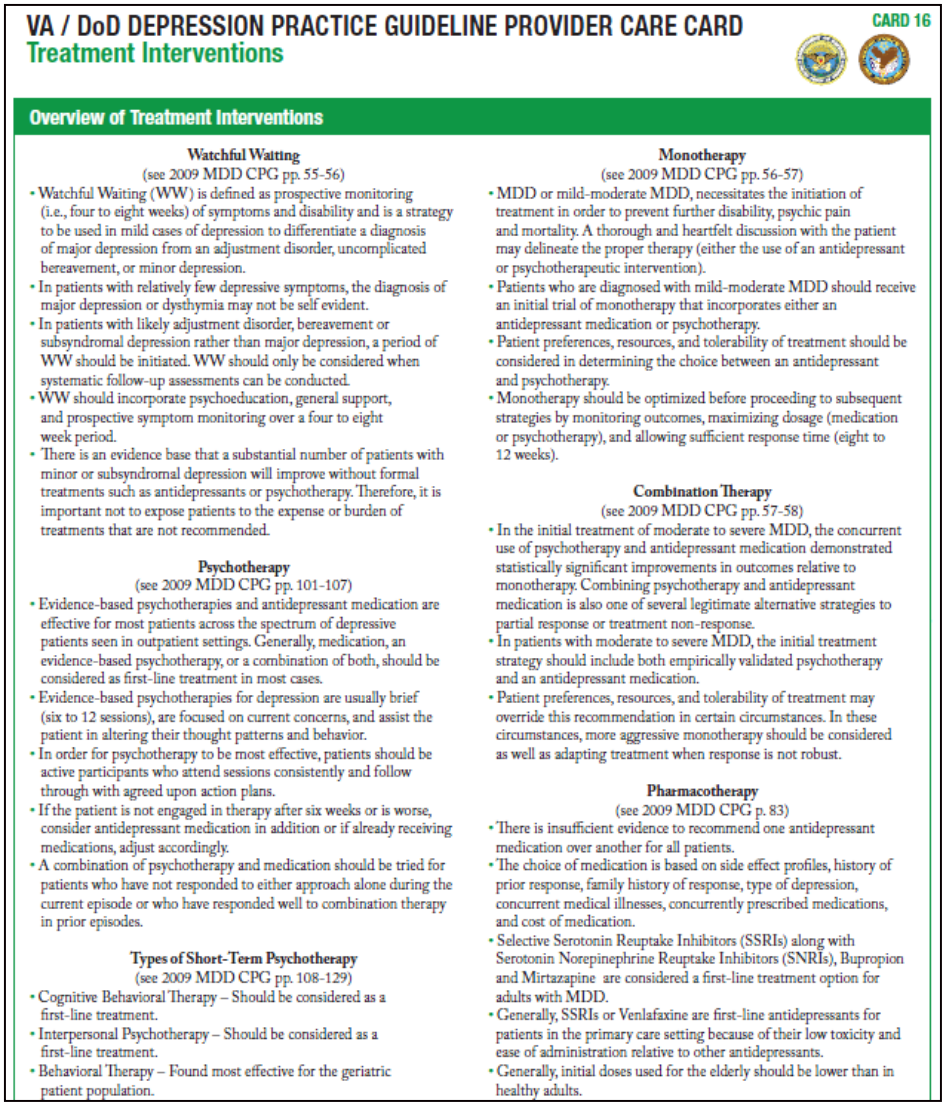
7. Cautiously use sleeping pills.
If you are currently using sleeping pills regularly, your care provider should medically supervise any changes.

8. Avoid caffeine, nicotine, and alcohol six to eight hours before bedtime.

Cards 16-17

The VA/DoD CPG

- **Overview of treatment interventions including:**
  - Psychotherapy
  - Pharmacotherapy
  - (Card 16)



VA / DoD DEPRESSION PRACTICE GUIDELINE PROVIDER CARE CARD

CARD 16

Treatment Interventions

Overview of Treatment Interventions

Watchful Waiting
(see 2009 MDD CPG pp. 55-56)

- Watchful Waiting (WW) is defined as prospective monitoring (i.e., four to eight weeks) of symptoms and disability and is a strategy to be used in mild cases of depression to differentiate a diagnosis of major depression from an adjustment disorder, uncomplicated bereavement, or minor depression.
- In patients with relatively few depressive symptoms, the diagnosis of major depression or dysthymia may not be self evident.
- In patients with likely adjustment disorder, bereavement or subsyndromal depression rather than major depression, a period of WW should be initiated. WW should only be considered when systematic follow-up assessments can be conducted.
- WW should incorporate psychoeducation, general support, and prospective symptom monitoring over a four to eight week period.
- There is an evidence base that a substantial number of patients with minor or subsyndromal depression will improve without formal treatments such as antidepressants or psychotherapy. Therefore, it is important not to expose patients to the expense or burden of treatments that are not recommended.

Psychotherapy
(see 2009 MDD CPG pp. 101-107)

- Evidence-based psychotherapies and antidepressant medication are effective for most patients across the spectrum of depressive patients seen in outpatient settings. Generally, medication, an evidence-based psychotherapy, or a combination of both, should be considered as first-line treatment in most cases.
- Evidence-based psychotherapies for depression are usually brief (six to 12 sessions), are focused on current concerns, and assist the patient in altering their thought patterns and behavior.
- In order for psychotherapy to be most effective, patients should be active participants who attend sessions consistently and follow through with agreed upon action plans.
- If the patient is not engaged in therapy after six weeks or is worse, consider antidepressant medication in addition or if already receiving medications, adjust accordingly.
- A combination of psychotherapy and medication should be tried for patients who have not responded to either approach alone during the current episode or who have responded well to combination therapy in prior episodes.

Types of Short-Term Psychotherapy
(see 2009 MDD CPG pp. 108-129)

- Cognitive Behavioral Therapy – Should be considered as a first-line treatment.
- Interpersonal Psychotherapy – Should be considered as a first-line treatment.
- Behavioral Therapy – Found most effective for the geriatric patient population.

Monotherapy
(see 2009 MDD CPG pp. 56-57)

- MDD or mild-moderate MDD, necessitates the initiation of treatment in order to prevent further disability, psychic pain and mortality. A thorough and heartfelt discussion with the patient may delineate the proper therapy (either the use of an antidepressant or psychotherapeutic intervention).
- Patients who are diagnosed with mild-moderate MDD should receive an initial trial of monotherapy that incorporates either an antidepressant medication or psychotherapy.
- Patient preferences, resources, and tolerability of treatment should be considered in determining the choice between an antidepressant and psychotherapy.
- Monotherapy should be optimized before proceeding to subsequent strategies by monitoring outcomes, maximizing dosage (medication or psychotherapy), and allowing sufficient response time (eight to 12 weeks).

Combination Therapy
(see 2009 MDD CPG pp. 57-58)

- In the initial treatment of moderate to severe MDD, the concurrent use of psychotherapy and antidepressant medication demonstrated statistically significant improvements in outcomes relative to monotherapy. Combining psychotherapy and antidepressant medication is also one of several legitimate alternative strategies to partial response or treatment non-response.
- In patients with moderate to severe MDD, the initial treatment strategy should include both empirically validated psychotherapy and an antidepressant medication.
- Patient preferences, resources, and tolerability of treatment may override this recommendation in certain circumstances. In these circumstances, more aggressive monotherapy should be considered as well as adapting treatment when response is not robust.

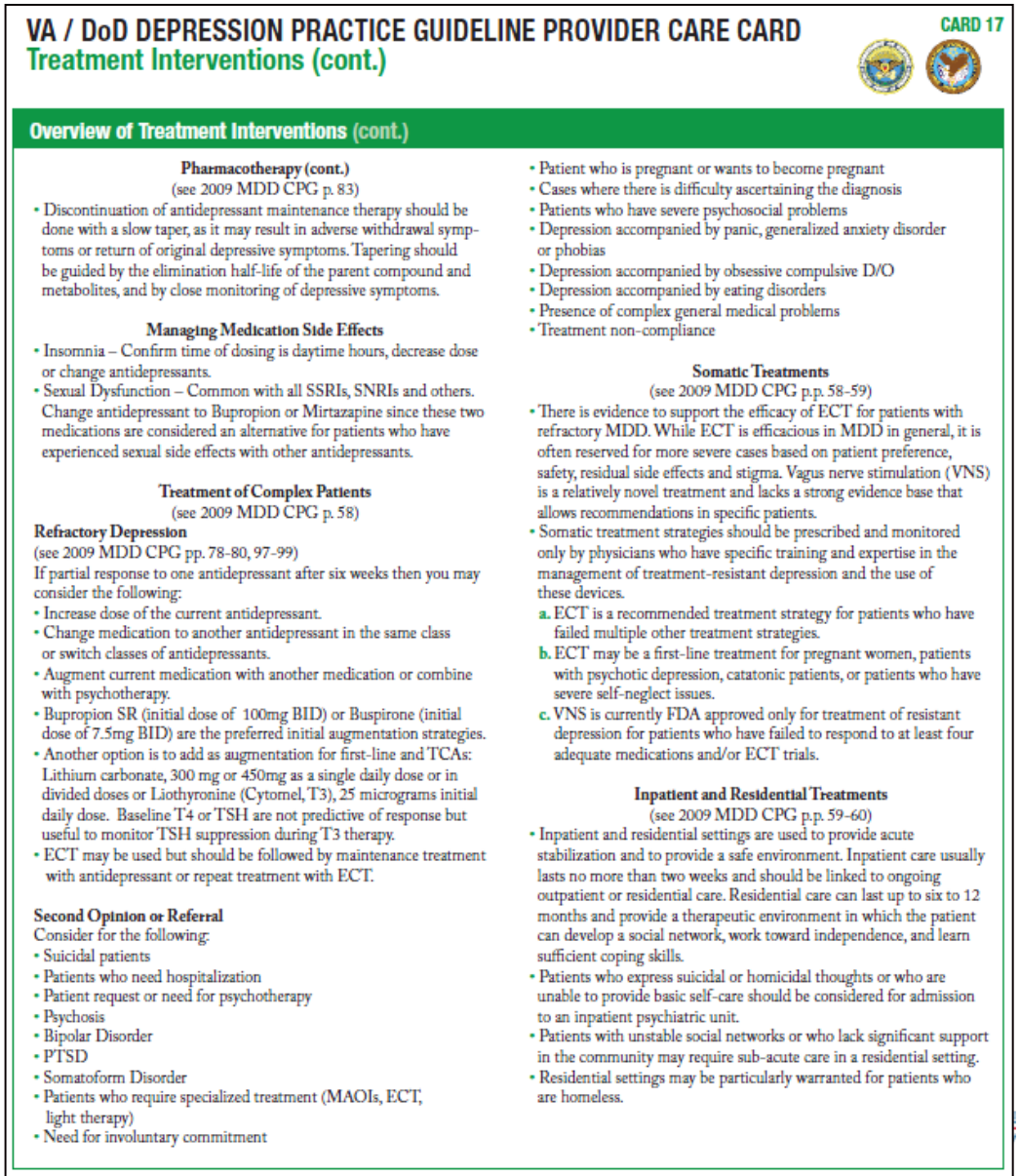
Pharmacotherapy
(see 2009 MDD CPG p. 83)

- There is insufficient evidence to recommend one antidepressant medication over another for all patients.
- The choice of medication is based on side effect profiles, history of prior response, family history of response, type of depression, concurrent medical illnesses, concurrently prescribed medications, and cost of medication.
- Selective Serotonin Reuptake Inhibitors (SSRIs) along with Serotonin Norepinephrine Reuptake Inhibitors (SNRIs), Bupropion and Mirtazapine are considered a first-line treatment option for adults with MDD.
- Generally, SSRIs or Venlafaxine are first-line antidepressants for patients in the primary care setting because of their low toxicity and ease of administration relative to other antidepressants.
- Generally, initial doses used for the elderly should be lower than in healthy adults.

Cards 16-17

The VA/DoD CPG

- **Treatment of complex patients**
  - (Card 17)



VA / DoD DEPRESSION PRACTICE GUIDELINE PROVIDER CARE CARD

CARD 17

Treatment Interventions (cont.)

Overview of Treatment Interventions (cont.)

Pharmacotherapy (cont.)
(see 2009 MDD CPG p. 83)

- Discontinuation of antidepressant maintenance therapy should be done with a slow taper, as it may result in adverse withdrawal symptoms or return of original depressive symptoms. Tapering should be guided by the elimination half-life of the parent compound and metabolites, and by close monitoring of depressive symptoms.

Managing Medication Side Effects

- Insomnia – Confirm time of dosing is daytime hours, decrease dose or change antidepressants.
- Sexual Dysfunction – Common with all SSRIs, SNRIs and others. Change antidepressant to Bupropion or Mirtazapine since these two medications are considered an alternative for patients who have experienced sexual side effects with other antidepressants.

Treatment of Complex Patients
(see 2009 MDD CPG p. 58)

Refractory Depression
(see 2009 MDD CPG pp. 78-80, 97-99)
If partial response to one antidepressant after six weeks then you may consider the following:

- Increase dose of the current antidepressant.
- Change medication to another antidepressant in the same class or switch classes of antidepressants.
- Augment current medication with another medication or combine with psychotherapy.
- Bupropion SR (initial dose of 100mg BID) or Buspirone (initial dose of 7.5mg BID) are the preferred initial augmentation strategies.
- Another option is to add as augmentation for first-line and TCAs: Lithium carbonate, 300 mg or 450mg as a single daily dose or in divided doses or Liothyronine (Cytomel, T3), 25 micrograms initial daily dose. Baseline T4 or TSH are not predictive of response but useful to monitor TSH suppression during T3 therapy.
- ECT may be used but should be followed by maintenance treatment with antidepressant or repeat treatment with ECT.

Second Opinion or Referral
Consider for the following:

- Suicidal patients
- Patients who need hospitalization
- Patient request or need for psychotherapy
- Psychosis
- Bipolar Disorder
- PTSD
- Somatoform Disorder
- Patients who require specialized treatment (MAOIs, ECT, light therapy)
- Need for involuntary commitment
- Patient who is pregnant or wants to become pregnant
- Cases where there is difficulty ascertaining the diagnosis
- Patients who have severe psychosocial problems
- Depression accompanied by panic, generalized anxiety disorder or phobias
- Depression accompanied by obsessive compulsive D/O
- Depression accompanied by eating disorders
- Presence of complex general medical problems
- Treatment non-compliance

Somatic Treatments
(see 2009 MDD CPG p.p. 58-59)

- There is evidence to support the efficacy of ECT for patients with refractory MDD. While ECT is efficacious in MDD in general, it is often reserved for more severe cases based on patient preference, safety, residual side effects and stigma. Vagus nerve stimulation (VNS) is a relatively novel treatment and lacks a strong evidence base that allows recommendations in specific patients.
- Somatic treatment strategies should be prescribed and monitored only by physicians who have specific training and expertise in the management of treatment-resistant depression and the use of these devices.
  a. ECT is a recommended treatment strategy for patients who have failed multiple other treatment strategies.
  b. ECT may be a first-line treatment for pregnant women, patients with psychotic depression, catatonic patients, or patients who have severe self-neglect issues.
  c. VNS is currently FDA approved only for treatment of resistant depression for patients who have failed to respond to at least four adequate medications and/or ECT trials.

Inpatient and Residential Treatments
(see 2009 MDD CPG p.p. 59-60)

- Inpatient and residential settings are used to provide acute stabilization and to provide a safe environment. Inpatient care usually lasts no more than two weeks and should be linked to ongoing outpatient or residential care. Residential care can last up to six to 12 months and provide a therapeutic environment in which the patient can develop a social network, work toward independence, and learn sufficient coping skills.
- Patients who express suicidal or homicidal thoughts or who are unable to provide basic self-care should be considered for admission to an inpatient psychiatric unit.
- Patients with unstable social networks or who lack significant support in the community may require sub-acute care in a residential setting.
- Residential settings may be particularly warranted for patients who are homeless.

Card 18

The VA/DoD CPG

- **Step-by-step recommendations for initiating medication treatment**
- **Guidance on when to reassess symptoms and suicidal risk**
- **Guidance on tolerability and adherence to medications**
- **When and how to re-evaluate the diagnosis and treatment plan if patients fail to respond to medications**

VA / DoD DEPRESSION PRACTICE GUIDELINE PROVIDER CARE CARD

CARD 18

Medication Treatment Response and Follow-Up

Treatment of Depression

Treatment Response and Follow-up (see 2009 MDD CPG p. 80)

STEP	PATIENT CONDITION	OPTIONS	REASSESS AT:
1	Initial Treatment	• Initiate low dose antidepressant	2 Weeks*
2	No response to initial low dose antidepressant	• Increase dose • Consider longer duration • Switch • Consider referral to specialty care	4 to 6 Weeks
3	Failed 2nd trial of antidepressant	• Switch • Augment or combine • Consider referral to specialty care	8 to 12 Weeks
4	Failed 3rd trial, including augmentation	• Reevaluate diagnosis and treatment • Consider referral to specialty care	12 to 18 Weeks

*If treatment is not tolerable, switch to another antidepressant.

Ongoing Clinical Assessment

- Initially, see patients frequently (every one to two weeks for four to six weeks) to assess treatment compliance and the patient's response. Assess/reassure the patient regarding side effects, adjust medication, evaluate risk factors for suicide, answer questions, rule out comorbid disorders and/or refer for counseling.
- When a therapeutic response has been reached (within about four to six weeks) continue dosage. Reassess at 12 weeks. If patient in symptom remission, continue medication at the same dosage for up to nine months. Conduct office visits or telephonic communication monthly following symptom remission.
- Maintenance phase treatment is recommended for patients with three or more episodes of major depression or two or more episodes in combination with another risk factor for recurrence. , or those in professions that involve safety (pilots, boat captains, etc.). In these cases, the patient should remain on prophylactic anti-depressant medication for one or more years after remission of the acute episode at the continuation phase dosage.

Assess Depressive Symptoms, Functional Status and Suicide Risk

- The PHQ-9 should be used to monitor treatment response at four to six weeks after initiation of treatment, after each change in treatment, and periodically until full remission is achieved.
- In patients who reach full remission, assessment of symptoms should be continued periodically to monitor for relapse or recurrence.
- Patients with suicidal ideation should have a careful evaluation of suicide risk.

Tolerability of Treatment

- Using a clinical interview, assess for treatment burden (e.g., medication side effects or adverse effects, attending appointments) after initiating or changing treatment, when the patient is non-adherent to treatment, or when the patient is not responding to treatment.
- Identified side effects should be managed to minimize or alleviate the side effects.

Adherence to Treatment

- Adherence should be assessed directly and routinely, targeting common reasons for nonadherence (e.g., side effects, lack of efficacy, feeling better).
- Providers should give simple educational messages regarding antidepressants in order to increase adherence to treatment in the acute phase of treatment.
- In primary care, utilize collaborative care personnel (e.g., nurses, social workers, psychologists) and systems strategies to enhance adherence to treatment beyond the acute phase.
- Collaborative care strategies used by mental health specialists focus on patient education via systematic in-person or telephonic follow-up/monitoring to address adherence, relapse prevention issues and self-management strategies.
- For patients who are at high risk for non-adherence to antidepressant medication, refer for psychotherapy to increase medication adherence and decrease the chance of treatment discontinuation.

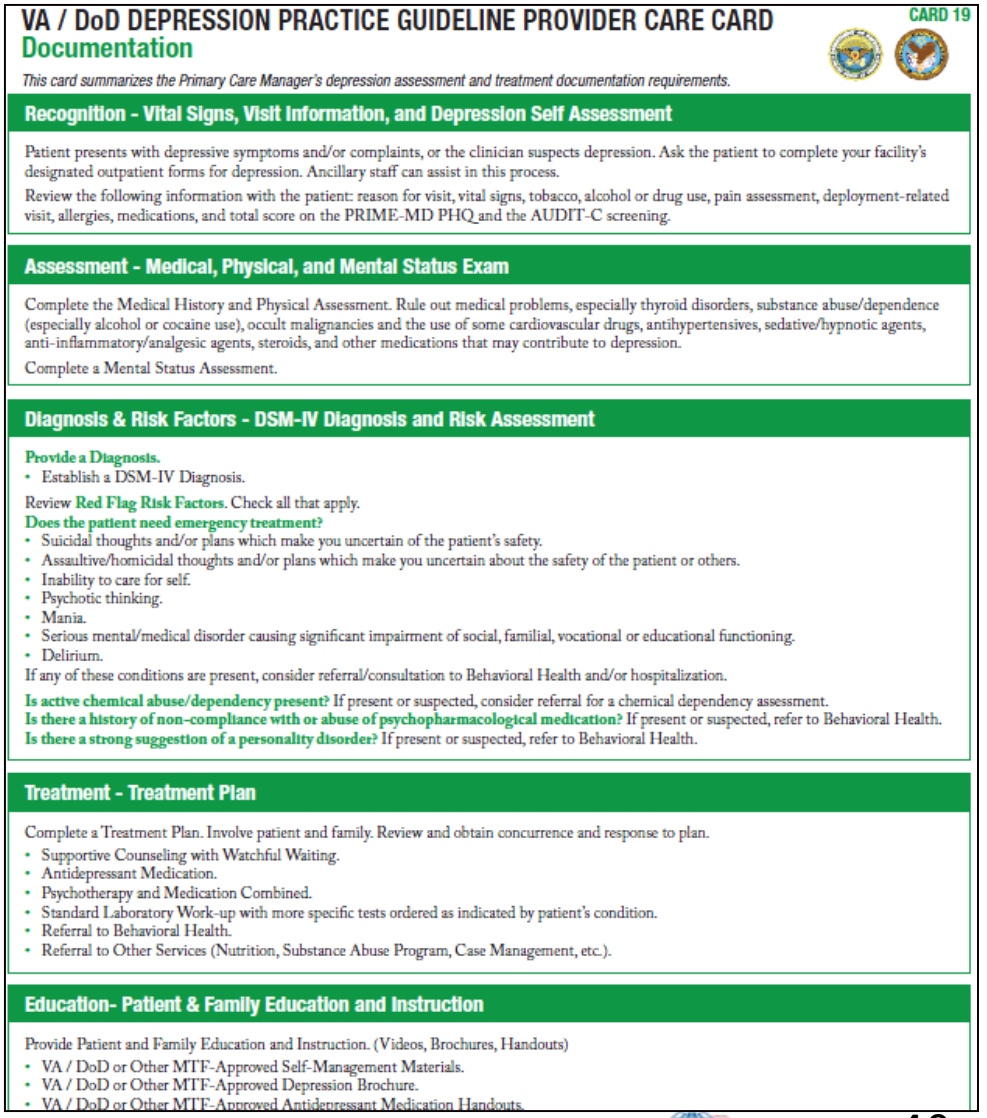
Reevaluate Diagnoses and Treatment Strategy for Non-Response

In treatment of non-responders, the diagnosis of MDD should be reconfirmed and the patient should be assessed for factors that may contribute to non-response. Referral to mental health specialty for a comprehensive assessment may be considered. Evaluation should include:

Card s 19-20

The VA/DoD CPG

- **Clinical notes that involve a mental health issue should include the following elements:**
  - Recognition
  - Assessment
  - Diagnosis
  - Treatment planning
  - Education
  - Monitoring and follow-up
- **System-level metrics can address:**
  - Aspects of care such as detection, diagnosis, outcomes
  - Criteria such as mental status exam (MSE), red flags, consultation, treatment plans



VA / DoD DEPRESSION PRACTICE GUIDELINE PROVIDER CARE CARD

CARD 19

Documentation

This card summarizes the Primary Care Manager's depression assessment and treatment documentation requirements.

Recognition - Vital Signs, Visit Information, and Depression Self Assessment

Patient presents with depressive symptoms and/or complaints, or the clinician suspects depression. Ask the patient to complete your facility's designated outpatient forms for depression. Ancillary staff can assist in this process.

Review the following information with the patient: reason for visit, vital signs, tobacco, alcohol or drug use, pain assessment, deployment-related visit, allergies, medications, and total score on the PRIME-MD PHQ and the AUDIT-C screening.

Assessment - Medical, Physical, and Mental Status Exam

Complete the Medical History and Physical Assessment. Rule out medical problems, especially thyroid disorders, substance abuse/dependence (especially alcohol or cocaine use), occult malignancies and the use of some cardiovascular drugs, antihypertensives, sedative/hypnotic agents, anti-inflammatory/analgesic agents, steroids, and other medications that may contribute to depression.

Complete a Mental Status Assessment.

Diagnosis & Risk Factors - DSM-IV Diagnosis and Risk Assessment

Provide a Diagnosis.
- Establish a DSM-IV Diagnosis.

Review **Red Flag Risk Factors**. Check all that apply.

Does the patient need emergency treatment?
- Suicidal thoughts and/or plans which make you uncertain of the patient's safety.
- Assaultive/homicidal thoughts and/or plans which make you uncertain about the safety of the patient or others.
- Inability to care for self.
- Psychotic thinking.
- Mania.
- Serious mental/medical disorder causing significant impairment of social, familial, vocational or educational functioning.
- Delirium.

If any of these conditions are present, consider referral/consultation to Behavioral Health and/or hospitalization.

Is active chemical abuse/dependency present? If present or suspected, consider referral for a chemical dependency assessment.
Is there a history of non-compliance with or abuse of psychopharmacological medication? If present or suspected, refer to Behavioral Health.
Is there a strong suggestion of a personality disorder? If present or suspected, refer to Behavioral Health.

Treatment - Treatment Plan

Complete a Treatment Plan. Involve patient and family. Review and obtain concurrence and response to plan.
- Supportive Counseling with Watchful Waiting.
- Antidepressant Medication.
- Psychotherapy and Medication Combined.
- Standard Laboratory Work-up with more specific tests ordered as indicated by patient's condition.
- Referral to Behavioral Health.
- Referral to Other Services (Nutrition, Substance Abuse Program, Case Management, etc.).

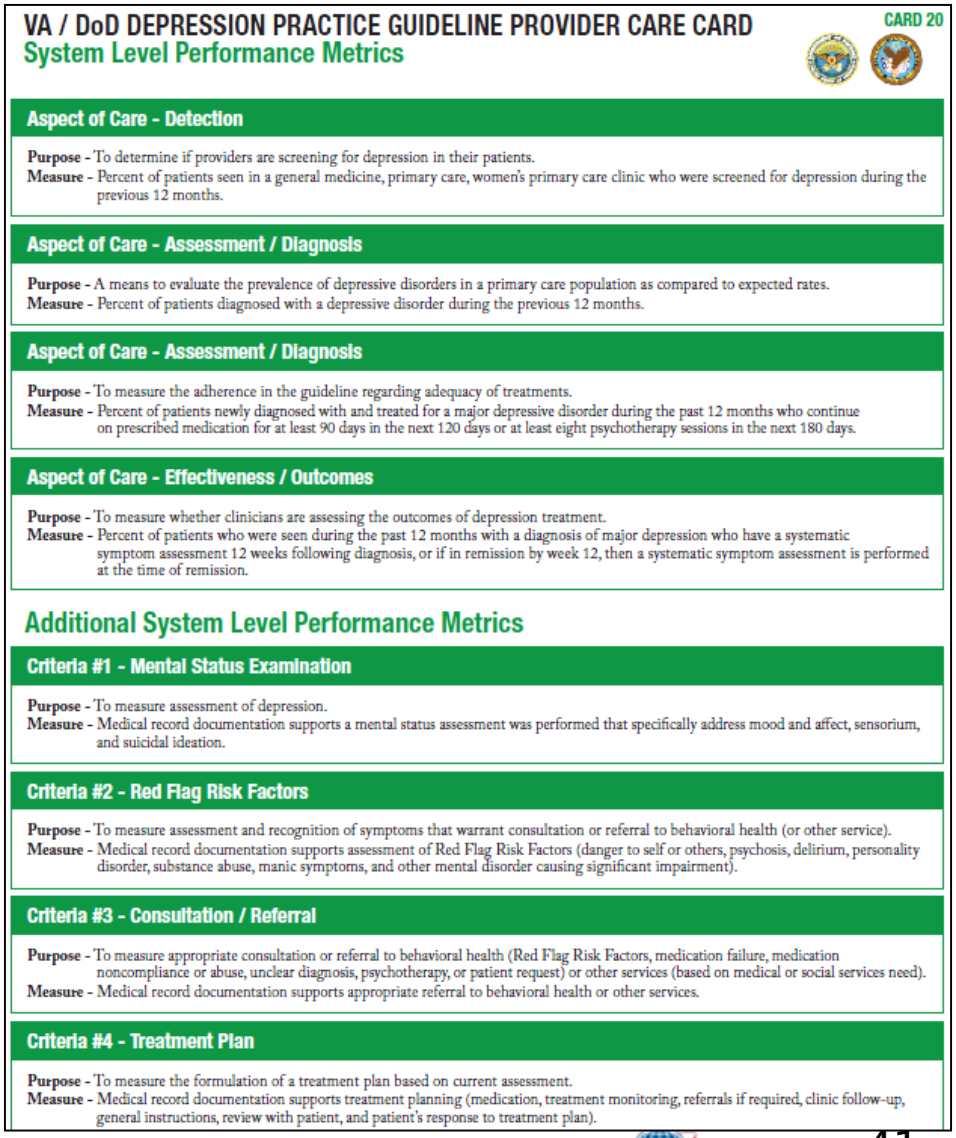
Education- Patient & Family Education and Instruction

Provide Patient and Family Education and Instruction. (Videos, Brochures, Handouts)
- VA / DoD or Other MTF-Approved Self-Management Materials.
- VA / DoD or Other MTF-Approved Depression Brochure.
- VA / DoD or Other MTF-Approved Antidepressant Medication Handouts.

Cards 19-20

The VA/DoD CPG

- **Clinical notes that involve a mental health issue should include the following elements:**
  - Recognition
  - Assessment
  - Diagnosis
  - Treatment planning
  - Education
  - Monitoring and follow-up
- **System-level metrics can address:**
  - Aspects of care such as detection, diagnosis, outcomes
  - Criteria such as MSE, red flags, consultation, treatment plans



VA / DoD DEPRESSION PRACTICE GUIDELINE PROVIDER CARE CARD

CARD 20

System Level Performance Metrics

Aspect of Care - Detection

Purpose - To determine if providers are screening for depression in their patients.
Measure - Percent of patients seen in a general medicine, primary care, women's primary care clinic who were screened for depression during the previous 12 months.

Aspect of Care - Assessment / Diagnosis

Purpose - A means to evaluate the prevalence of depressive disorders in a primary care population as compared to expected rates.
Measure - Percent of patients diagnosed with a depressive disorder during the previous 12 months.

Aspect of Care - Assessment / Diagnosis

Purpose - To measure the adherence in the guideline regarding adequacy of treatments.
Measure - Percent of patients newly diagnosed with and treated for a major depressive disorder during the past 12 months who continue on prescribed medication for at least 90 days in the next 120 days or at least eight psychotherapy sessions in the next 180 days.

Aspect of Care - Effectiveness / Outcomes

Purpose - To measure whether clinicians are assessing the outcomes of depression treatment.
Measure - Percent of patients who were seen during the past 12 months with a diagnosis of major depression who have a systematic symptom assessment 12 weeks following diagnosis, or if in remission by week 12, then a systematic symptom assessment is performed at the time of remission.

Additional System Level Performance Metrics

Criteria #1 - Mental Status Examination

Purpose - To measure assessment of depression.
Measure - Medical record documentation supports a mental status assessment was performed that specifically address mood and affect, sensorium, and suicidal ideation.

Criteria #2 - Red Flag Risk Factors

Purpose - To measure assessment and recognition of symptoms that warrant consultation or referral to behavioral health (or other service).
Measure - Medical record documentation supports assessment of Red Flag Risk Factors (danger to self or others, psychosis, delirium, personality disorder, substance abuse, manic symptoms, and other mental disorder causing significant impairment).

Criteria #3 - Consultation / Referral

Purpose - To measure appropriate consultation or referral to behavioral health (Red Flag Risk Factors, medication failure, medication noncompliance or abuse, unclear diagnosis, psychotherapy, or patient request) or other services (based on medical or social services need).
Measure - Medical record documentation supports appropriate referral to behavioral health or other services.

Criteria #4 - Treatment Plan

Purpose - To measure the formulation of a treatment plan based on current assessment.
Measure - Medical record documentation supports treatment planning (medication, treatment monitoring, referrals if required, clinic follow-up, general instructions, review with patient, and patient's response to treatment plan).

Cards 21-31

The VA/DoD CPG

VA / DoD – DEPRESSION PRACTICE GUIDELINE PROVIDER CARE CARD

CARD 21

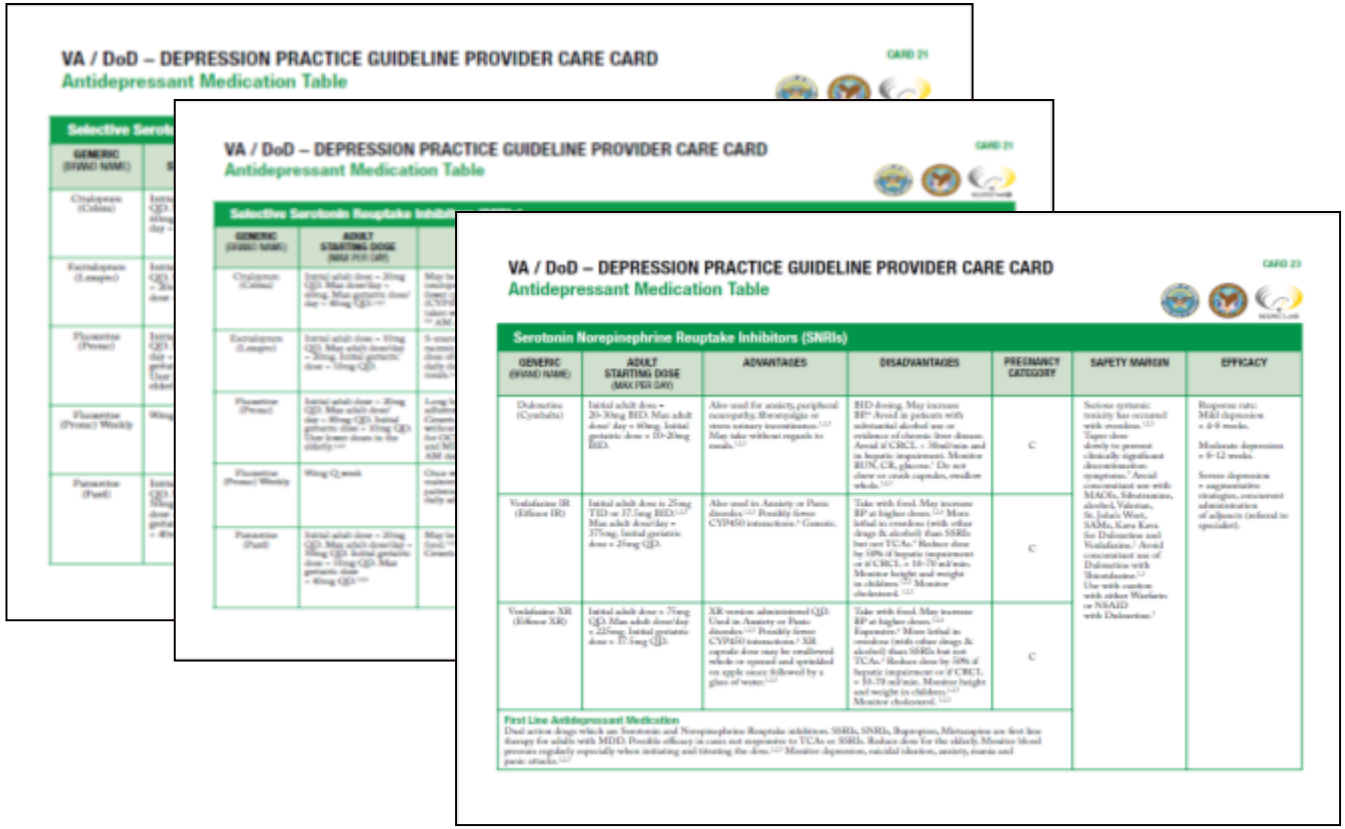
Antidepressant Medication Table

Selective Serotonin Reuptake Inhibitors (SSRIs)

GENERIC (BRAND NAME)	ADULT STARTING DOSE (MAX PER DAY)	ADVANTAGES	DISADVANTAGES	PREGNANCY CATEGORY	SAFETY MARGIN	EFFICACY
Citalopram (Celexa)	Initial adult dose = 20mg QD. Max dose/day = 60mg. Max geriatric dose/day = 40mg QD.[1,2,3]	May be used for diabetic neuropathy.[1,2] Generic. Possibly fewer cytochrome P450 (CYP450) Interactions.[4] May be taken without regard to meals.[1, 2,3] AM daily dosing.	No evidence of increased efficacy by dose escalation within the first 4 weeks. Dose escalation after 6 weeks appeared less effective than continuing the same dose.	C	Serious systemic toxicity has occurred with overdose.[1,2,3] Taper dose slowly to prevent clinically significant discontinuation symptoms.[7] Drug interactions may include MAOIs, Tricyclic Antidepressants, Carbamazepine, Warfarin, Nilotinib, Pimozide, Sibutramine, Tamoxifen, Tetrabenazine, Thioridazine and Ziprasidone.[5]	Response rate: Mild depression = 4-8 weeks. Moderate depression = 8-12 weeks. Severe depression = augmentative strategies, concurrent administration of adjuncts (referral to specialist).
Escitalopram (Lexapro)	Initial adult dose = 10mg QD. Max adult dose/day = 20mg. Initial geriatric dose = 10mg QD.	S-enantiomer more potent than racemic (Citalopram).[4] 10mg dose often effective.[4] Once daily dosing without regard to meals.[1,2,3] AM daily dosing.	No evidence of increased efficacy by dose escalation within the first 4 weeks. Dose escalation after 6 weeks appeared less effective than continuing the same dose.	C		
Fluoxetine (Prozac)	Initial adult dose = 20mg QD. Max adult dose/day = 80mg QD. Initial geriatric dose = 10mg QD. Use lower doses in the elderly.[1,2,3]	Long half-life good for poor adherence, missed doses.[4] Generic. May be taken with or without food.[1,2] FDA approved for OCD use in children =>7 and MDD in children =>8.[1,2,3] AM daily dosing.	Slower to reach steady state.[4] Sometimes too stimulating.[4] Possibly more CYP450 interactions.[3,4] Should not be taken at night in the elderly unless for sedation.[1] Associated with rash and allergic events.[1,2,3]	C		
Fluoxetine (Prozac) Weekly	90mg Q week	Once weekly dosing in the maintenance therapy for patients who have responded to daily administration.[1,2,3]	If a satisfactory response is not maintained with once weekly dosing, consider re-establishing a daily dosing regimen.[1,2,3] Possibly more CYP450 interactions.[3,4]	C		
Paroxetine (Paxil)	Initial adult dose = 20mg QD. Max adult dose/day = 50mg QD. Initial geriatric dose = 10mg QD. Max geriatric dose = 40mg QD.[1,2,3]	May be taken with or without food.[1,2,3] Am daily dosing. Generic.	Of the SSRIs, highest reported dc rate, highest rate of sexual dysfunction and weight gain. Sometimes sedating and more anti-cholinergic symptoms.[4] Possibly more CYP450 interactions.[4] Avoid in pregnancy.	D		

Cards 21-31

The VA/DoD CPG



Cards 32-33

The VA/DoD CPG

VA / DoD – DEPRESSION PRACTICE GUIDELINE PROVIDER CARE CARD

CARD 32

Antidepressant Medication Table

Black Box Warning for all Antidepressants: Antidepressants increase the risk of suicidal thinking and behavior in young adults (18-24) with MDD and other psychiatric disorders.[1,2,3] Appropriately monitor and closely observe for clinical worsening, suicidality or unusual changes in behavior particularly during the initial 1-2 months and during periods of dosage adjustments.[1,2,3] Short-term studies did not show an increase in the risk of suicidality with Antidepressants compared to placebo in adults beyond age 24; there was a reduction in risk with Antidepressants compared to placebo in adults aged 65 and older.[1,2,3]

Medications That Can Cause Depression

MEDICATION/CLASS	ASSOCIATION	COMMENTS
Beta-Blockers	+/-	Recent, better designed investigations have not supported earlier findings that beta-blockers increase the risk of depression. Propranolol and Sotalol have side effects labeled as depression.
Calcium-Channel Blockers (CCBs)	+/-	An association between CCBs and depression or suicide has been reported in some studies; other studies have not found an association.
ACE-inhibitors	+/-	Conflicting reports of an association; some trials have reported an improvement in mood.
Lipid-lowering agents	+/-	A meta-analysis reported an association between cholesterol lowering and suicide, violent, and accidental deaths. It is not clear whether the increased risk of mortality was secondary to the lowered cholesterol or the intervention(s). No such association has been found with the newer lipid-lowering agents (i.e., the statins).
Reserpine, Clonidine, Methyldopa	+	Reserpine and the other rauwolfia alkaloids have long been associated with depression. The frequency and strength of association may have been exaggerated by the high doses used in the past. Clonidine and methyldopa may also cause sedation and symptoms of depression.
Corticosteroids	+	The majority of studies support an association. Corticosteroids, particularly higher doses, are associated with psychosis and mania.
Selective estrogen receptor modulators (SERM)	+/-	Data primarily suggest a lack of relationship between SERMs and depression. Confounding by diagnosis (usually breast cancer) may account for positive links.
NSAIDs	+	Rare psychiatric symptoms, not limited to depression, have been seen.
H2-antagonists	-	No association found in small studies.
Benzodiazepines and Barbiturates	+	Primarily a concern in older patients who use chronically or those who abuse. Toxicity, namely sedation, may be mistaken for depressive symptoms.
Topiramate	+	Known to have CNS effects (confusion and poor concentration) which may be mistaken for depressive symptoms.
Progesterone implants	+/-	Levonorgestrel has been associated with depression. Medroxyprogesterone acetate has been reported to slightly increase the risk for depression in one study.

Cards 32-33

The VA/DoD CPG

VA / DoD – DEPRESSION PRACTICE GUIDELINE PROVIDER CARE CARD

CARD 32

Antidepressant Medication Table

Black Box Warning for all Antidepressants: Antidepressants increase the risk of suicidal thinking and behavior in young adults (18-24) with MDD and other psychiatric disorders. Appropriately monitor and closely observe for clinical worsening, suicidality, or unusual changes in behavior particularly during the initial 2 months and during periods of dosage adjustments.[1,2,3] Short-term studies did not show an increase in the risk of suicidality with Antidepressants compared to placebo in adults beyond age 24; there was a reduction in risk with Antidepressants compared to placebo in adults aged 65 and older.[1,2,3]

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Selective estrogen receptor modulators (SERM)	+/-	Data primarily suggest a lack of relationship between SERMs and depression. Confounding by diagnosis (usually breast cancer) may account for positive links.
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Progesterone implants	+/-	Levonorgestrel has been associated with depression. Medroxyprogesterone acetate has been reported to slightly increase the risk for depression in one study.

Cards 34-35

The VA/DoD CPG

VA / DoD – DEPRESSION PRACTICE GUIDELINE PROVIDER CARE CARD

CARD 34

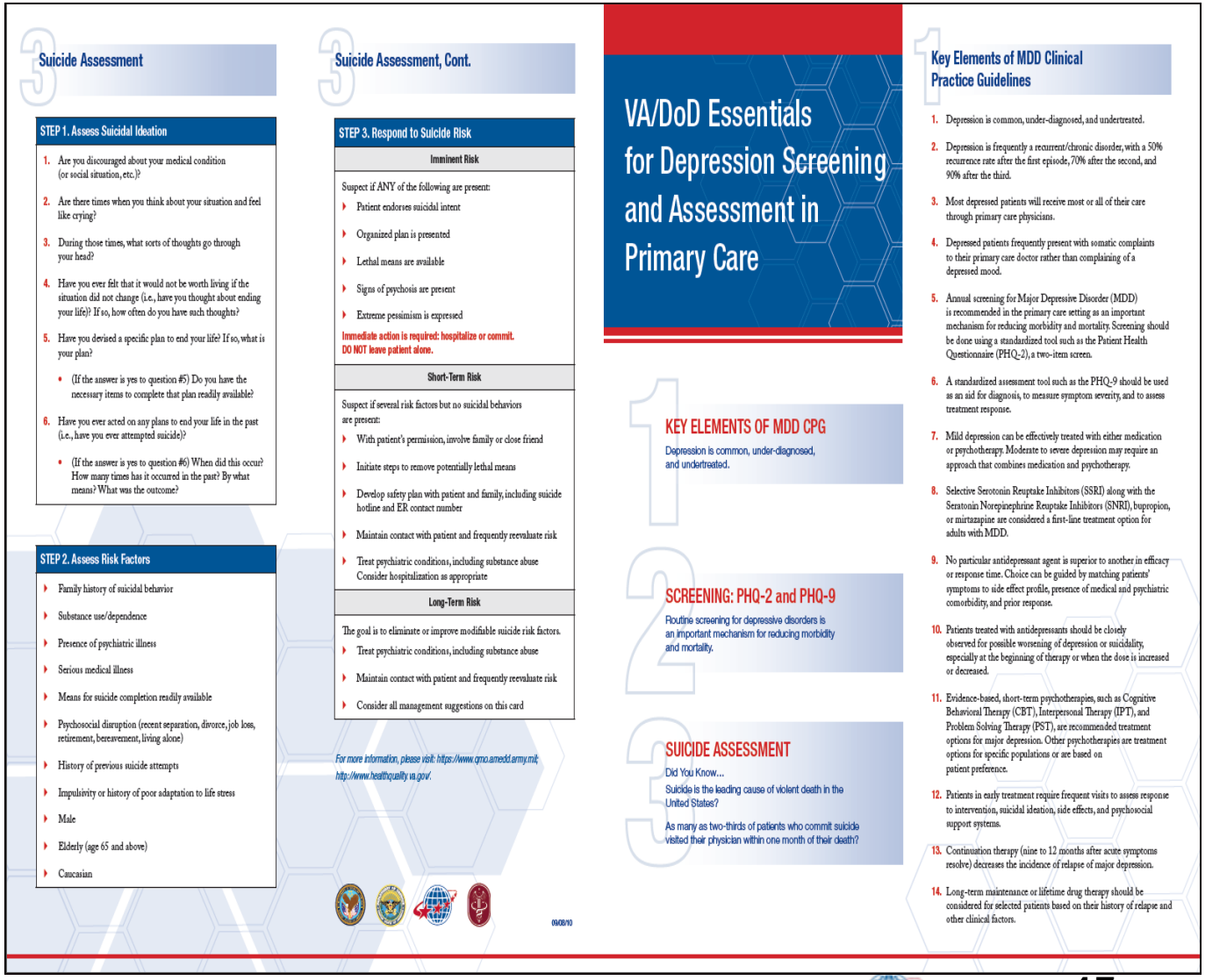
Antidepressant Medication Table

Antidepressant Adverse Drug Effects: Relative Comparisons[5]

MEDICATION NAME	ANTICHOLINERGIC ACTIVITY (MUSCARINIC)	SEDATION (H_1)	ORTHOSTATIC HYPOTENSION ($ALPHA_1$)	CARDIAC EFFECTS	GI EFFECTS	SEIZURES	WEIGHT GAIN	SEXUAL DYSFUNCTION
Citalopram	0	0/+	0	0	+++	0	0	+++
Escitalopram	0	0/+	0	0	+++	0	0	+++
Fluoxetine	0	0/+	0	0/+	+++	0/+	0/+	+++
Paroxetine	0/+	0/+	0	0	+++	0	0/+	+++
Sertraline	0	0/+	0	0	+++	0	0	+++
Duloxetine	0	0/+	0/+	0/+	+++	0	0/+	+++
Venlafaxine	0	0	0	0/+	+++	0	0	+++
Bupropion	0	0	0	0	++	+++	0	0
Nefazodone	0	+++	0	0/+	++		0/+	0/+
Trazodone	0	+++	0	0/+	++	0	+	+
Mirtazapine	0	+++	0/+	0	0/+	0	0/+	0
Amitriptyline	+++	+++	+++	+++	0/+	++	++	++
Imipramine	++	++	++	+++	0/+	++	++	++
Nortriptyline	+	+	+	++	0/+	+	+	++
Desipramine	+	0/+	+	++	0/+	+	+	++
Doxepin	++	+++	++	+++	0/+	++	++	++

The VA/DoD CPG

- **Key elements of MDD CPG**
- **Suicide assessment**
- **The patient health questionnaires**



3 Suicide Assessment

STEP 1. Assess Suicidal Ideation

1. Are you discouraged about your medical condition (or social situation, etc.)?
2. Are there times when you think about your situation and feel like crying?
3. During those times, what sorts of thoughts go through your head?
4. Have you ever felt that it would not be worth living if the situation did not change (i.e., have you thought about ending your life)? If so, how often do you have such thoughts?
5. Have you devised a specific plan to end your life? If so, what is your plan?
   - (If the answer is yes to question #5) Do you have the necessary items to complete that plan readily available?
6. Have you ever acted on any plans to end your life in the past (i.e., have you ever attempted suicide)?
   - (If the answer is yes to question #6) When did this occur? How many times has it occurred in the past? By what means? What was the outcome?

STEP 2. Assess Risk Factors

- Family history of suicidal behavior
- Substance use/dependence
- Presence of psychiatric illness
- Serious medical illness
- Means for suicide completion readily available
- Psychosocial disruption (recent separation, divorce, job loss, retirement, bereavement, living alone)
- History of previous suicide attempts
- Impulsivity or history of poor adaptation to life stress
- Male
- Elderly (age 65 and above)
- Caucasian

3 Suicide Assessment, Cont.

STEP 3. Respond to Suicide Risk

Imminent Risk

Suspect if ANY of the following are present:

- Patient endorses suicidal intent
- Organized plan is presented
- Lethal means are available
- Signs of psychosis are present
- Extreme pessimism is expressed

Immediate action is required: hospitalize or commit. DO NOT leave patient alone.

Short-Term Risk

Suspect if several risk factors but no suicidal behaviors are present:

- With patient's permission, involve family or close friend
- Initiate steps to remove potentially lethal means
- Develop safety plan with patient and family, including suicide hotline and ER contact number
- Maintain contact with patient and frequently reevaluate risk
- Treat psychiatric conditions, including substance abuse Consider hospitalization as appropriate

Long-Term Risk

The goal is to eliminate or improve modifiable suicide risk factors.

- Treat psychiatric conditions, including substance abuse
- Maintain contact with patient and frequently reevaluate risk
- Consider all management suggestions on this card

For more information, please visit: https://www.qmo.amedd.army.mil; http://www.healthquality.va.gov/.

09/08/10

VA/DoD Essentials for Depression Screening and Assessment in Primary Care

1 KEY ELEMENTS OF MDD CPG

Depression is common, under-diagnosed, and undertreated.

2 SCREENING: PHQ-2 and PHQ-9

Routine screening for depressive disorders is an important mechanism for reducing morbidity and mortality.

3 SUICIDE ASSESSMENT

Did You Know...

Suicide is the leading cause of violent death in the United States?

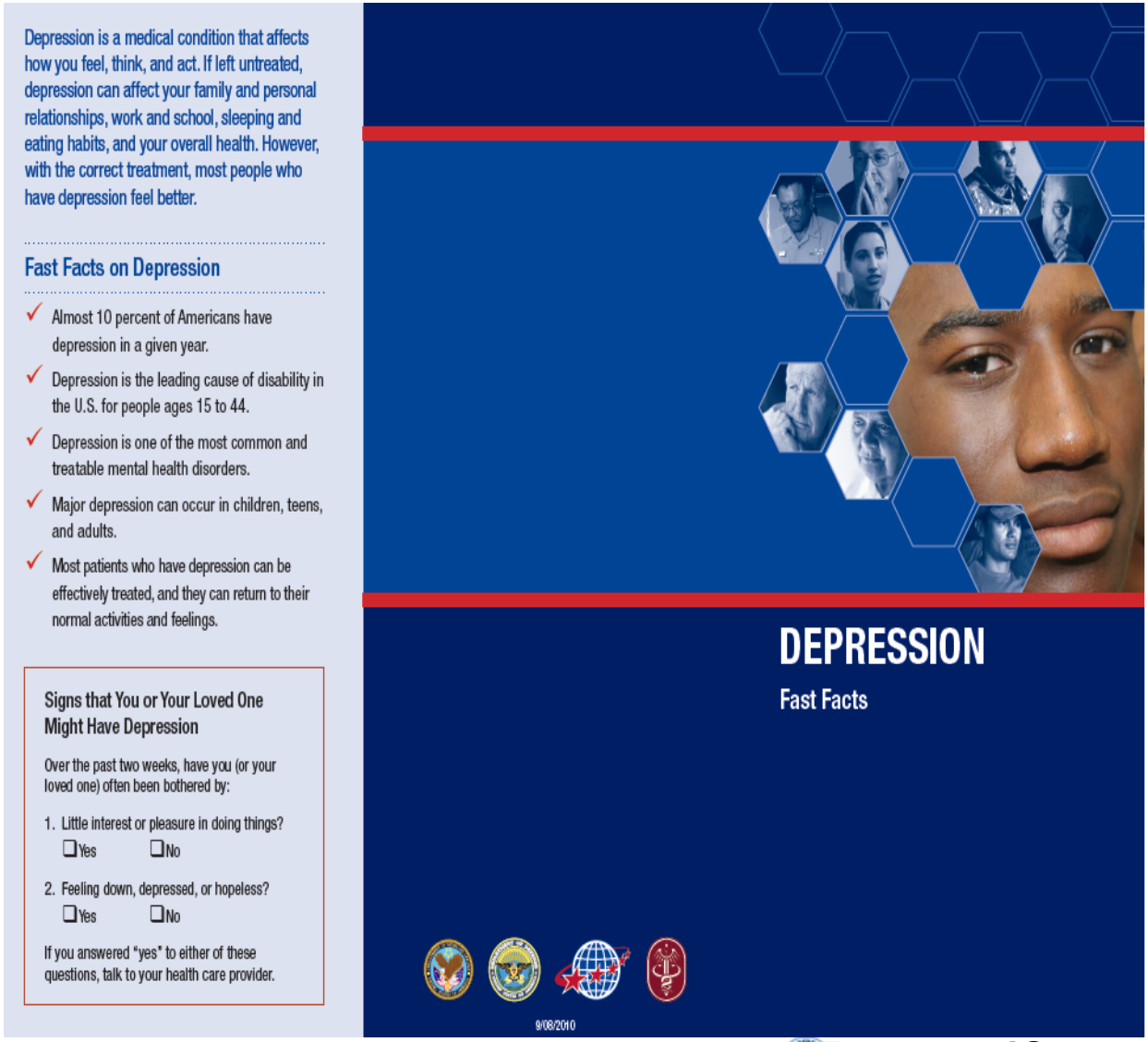
As many as two-thirds of patients who commit suicide visited their physician within one month of their death?

1 Key Elements of MDD Clinical Practice Guidelines

1. Depression is common, under-diagnosed, and undertreated.
2. Depression is frequently a recurrent/chronic disorder, with a 50% recurrence rate after the first episode, 70% after the second, and 90% after the third.
3. Most depressed patients will receive most or all of their care through primary care physicians.
4. Depressed patients frequently present with somatic complaints to their primary care doctor rather than complaining of a depressed mood.
5. Annual screening for Major Depressive Disorder (MDD) is recommended in the primary care setting as an important mechanism for reducing morbidity and mortality. Screening should be done using a standardized tool such as the Patient Health Questionnaire (PHQ-2), a two-item screen.
6. A standardized assessment tool such as the PHQ-9 should be used as an aid for diagnosis, to measure symptom severity, and to assess treatment response.
7. Mild depression can be effectively treated with either medication or psychotherapy. Moderate to severe depression may require an approach that combines medication and psychotherapy.
8. Selective Serotonin Reuptake Inhibitors (SSRI) along with the Seratonin Norepinephrine Reuptake Inhibitors (SNRI), bupropion, or mirtazapine are considered a first-line treatment option for adults with MDD.
9. No particular antidepressant agent is superior to another in efficacy or response time. Choice can be guided by matching patients' symptoms to side effect profile, presence of medical and psychiatric comorbidity, and prior response.
10. Patients treated with antidepressants should be closely observed for possible worsening of depression or suicidality, especially at the beginning of therapy or when the dose is increased or decreased.
11. Evidence-based, short-term psychotherapies, such as Cognitive Behavioral Therapy (CBT), Interpersonal Therapy (IPT), and Problem Solving Therapy (PST), are recommended treatment options for major depression. Other psychotherapies are treatment options for specific populations or are based on patient preference.
12. Patients in early treatment require frequent visits to assess response to intervention, suicidal ideation, side effects, and psychosocial support systems.
13. Continuation therapy (nine to 12 months after acute symptoms resolve) decreases the incidence of relapse of major depression.
14. Long-term maintenance or lifetime drug therapy should be considered for selected patients based on their history of relapse and other clinical factors.

The VA/DoD CPG

- **Fast facts**
- **Symptoms**
- **Causes**
- **Helpful activities**
- **Treatments**
- **Medications**
- **Patient and provider roles in treatment**



Depression is a medical condition that affects how you feel, think, and act. If left untreated, depression can affect your family and personal relationships, work and school, sleeping and eating habits, and your overall health. However, with the correct treatment, most people who have depression feel better.

Fast Facts on Depression

- ✓ Almost 10 percent of Americans have depression in a given year.
- ✓ Depression is the leading cause of disability in the U.S. for people ages 15 to 44.
- ✓ Depression is one of the most common and treatable mental health disorders.
- ✓ Major depression can occur in children, teens, and adults.
- ✓ Most patients who have depression can be effectively treated, and they can return to their normal activities and feelings.

Signs that You or Your Loved One Might Have Depression

Over the past two weeks, have you (or your loved one) often been bothered by:

1. Little interest or pleasure in doing things?
   ❑Yes ❑No
2. Feeling down, depressed, or hopeless?
   ❑Yes ❑No

If you answered "yes" to either of these questions, talk to your health care provider.

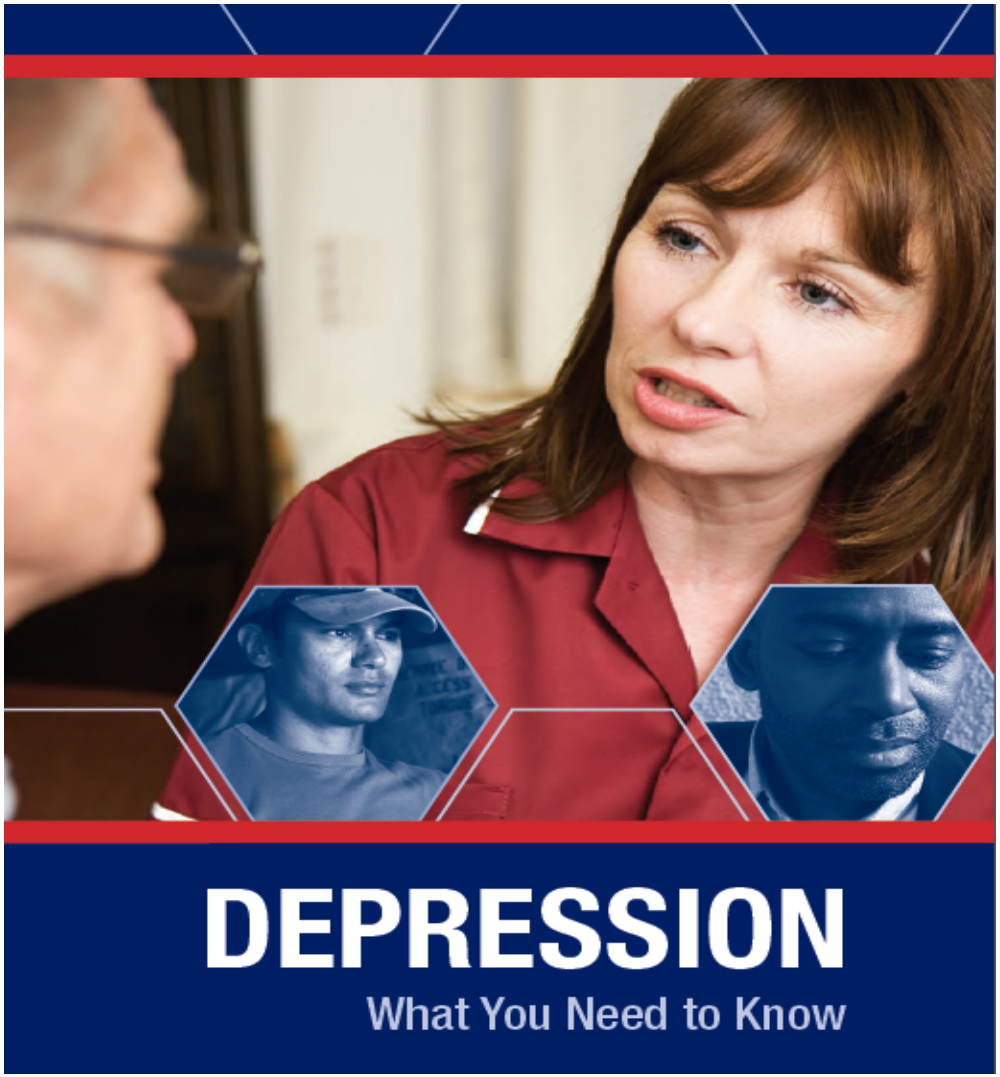
DEPRESSION

Fast Facts

9/08/2010

The VA/DoD CPG

- Causes
- Treatment
- Self management
- Medications
- Questions from friends, family and children
- Sleep hygiene
- Worksheets
- Resources



Conclusion

- **We briefly reviewed the development of the MDD Clinical Practice Guideline**
- **We covered the content of the tool kit**
  - Tool kit cards
  - Patient education materials
- **We described the benefits of utilizing these tools**
  - Decreased practice variation
  - Improved patient outcomes
  - Effective decision-making
  - Decreased risk

Additional Information

Major Depressive Disorder CPG

http://www.healthquality.va.gov/MDD_FULL_3c.pdf

U.S. Army Office of Quality Management

https://www.qmo.amedd.army.mil/depress/depress.htm

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Feedback

DCoE requests your Interactive Customer Evaluation (ICE) feedback regarding the Major Depressive Disorder Toolkit Training Manual. The results of this feedback will allow DCoE to
track the impact of the manual and set goals around education and dissemination while continuously improving this and other DCoE Education products. Please take a few moments to complete the ICE:
http://ice.disa.mil/index.cfm?fa=card&s=1019&sp=127907&dep=*DoD.